

F-660

68 1001

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68 1001

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

IRVIN

FUHRER

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Room #9, 201 E. North Avenue

2. DATE OF DEATH Known ☐ Estimated ☒ Month Day Year Hour M.
January 16, 19683. DATE PRONOUNCED DEAD Month Day Year Hour M.
January 22, 1968 6:40 P.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

6. SEX

Male

7. RACE

white

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Nov. 6, 1911

10. AGE (In years lost birthday)

56

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

Room #9, 201 E. North Avenue

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Louis Fuhrer

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Printer

14B. KIND OF BUSINESS OR INDUSTRY

Residential

15. MOTHER'S MAIDEN NAME

Annie Maldeis

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

None

17. SOCIAL SECURITY NO.

212-18-3596

18. INFORMANT

Wm. E. Fuhrer 2429 McElderry St.

ADDRESS

19. 4/29 I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/23/68

24A. BURIAL CREMATION, REMOVAL (Specify)

Cremation

24B. DATE

1-24-68

24C. NAME OF CEMETERY or CREMATORY

London Park

24D. LOCATION (City, town, or county) (State)

BALTIMORE, Md

25A. DATE REC'D BY HEALTH DEPT.

JAN 25 1968

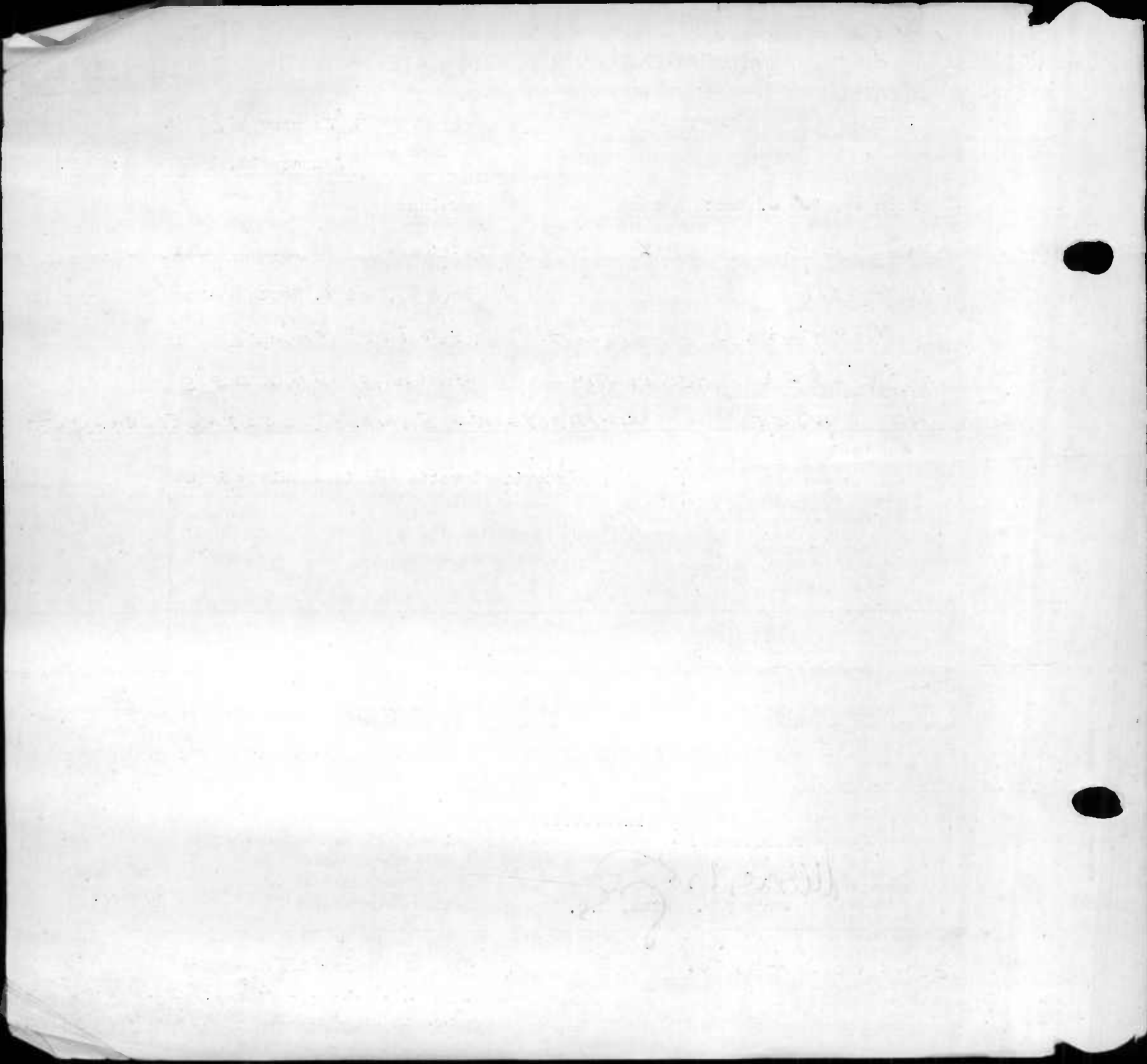
25B. NAME OF REGISTRAR

Robert E. Johnson

25C. FUNERAL DIRECTOR

Francis W. Miller 2101 Frederick Ave

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-525		68 1002		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68 1002	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>Johnson, Claudia</u>			
2. DATE AND HOUR OF DEATH <u>1/23/68</u>				9:40 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Harford</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>The Johns Hopkins Hospital</u>				C. CITY OR TOWN <u>Fallston</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <u>Rt 2, Box 235 Hess Road</u>			
5. SEX <u>Female</u>	6. RACE <u>Negroid</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/16/97</u>	9. AGE (In years last birthday) <u>70</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Jones</u>				14. MOTHER'S MAIDEN NAME <u>Mary Wise</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-32-4454</u>		17. INFORMANT <u>J. Howard Johnson</u> ADDRESS <u>Hess Road Fallston, Maryland</u>			
18. <u>1729</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia - aspiration</u> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Possible metastatic uterine tumor</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>8 months</u>							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>214X</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>_____</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>_____</u>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>_____</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>_____</u>			
22. I certify that (1) (this hospital) attended the deceased from <u>Jan. 22</u> 19 <u>68</u> to <u>Jan. 23</u> 19 <u>68</u> , that (1) (we) last saw the deceased alive on <u>Jan. 23</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>J. Graber, M.D.</u>				23B. DATE SIGNED <u>Jan. 23, 1968</u>		23C. PHYSICIAN'S NAME (Type) <u>John D. Graber</u>	
23D. ADDRESS <u>Johns Hopkins Hospital</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					
24B. DATE <u>1/27/1968</u>		24C. NAME OF CEMETERY or CREMATORY <u>West Liberty M. E.</u>		24D. LOCATION (City, town, or county) (State) <u>Fallston, Harford, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Jarrett</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Charles E. Kurtz Jarrettsville, Md.</u>			

A 24.4

2.53.4

2.53.4

2.53.4

2.53.4

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
REG. NO. <u>68 1003</u>									
BIRTH NO. <u>68 1003</u>		CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) DEMPSEY, SADIE F					2. DATE AND HOUR OF DEATH 01 23 68 1:20A				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 25-31				
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL					C. CITY OR TOWN BALTO 21229		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
					E. STREET AND NUMBER 4905 STAFFORD ST.				
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 01 14 88	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTO MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME AUGUST FEUERHERD			14. MOTHER'S MAIDEN NAME BARBARA MURDOCK Murbach			17. INFORMATION CATON BALTO MD 21229			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 213 26 4709		ADDRESS 4709 ST AGNES HOSP RECORDS, WILKENS &				
18. 441.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Ruptured Aortic Aneurysm CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
19. 451X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 01 20 19 68 to 01 23 19 68 , the <input checked="" type="checkbox"/> (we) last saw the deceased alive on 01 23 19 68 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) did <input checked="" type="checkbox"/> (not) view the body after death.									
23A. SIGNATURE <i>Romualdo R. Dator, M.D.</i>					23B. DATE SIGNED <i>Jan. 23, 1968</i>			23C. PHYSICIAN'S NAME (Type) <i>Romualdo R. Dator, M.D.</i>	
23D. ADDRESS <i>St. Agnes Hospital Baltimore, Md.</i>									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-26-1968		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1968			25B. NAME OF REGISTRAR <i>Robert E. Farber</i>		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			ADDRESS	

12:1

12:10

12:10

12:10

12:10

12:10

12:10

12:10

12:10

12:10

12:10

12:10

12:10

12:10

12:10

12:10

12:10

12:10

12:10

12:10

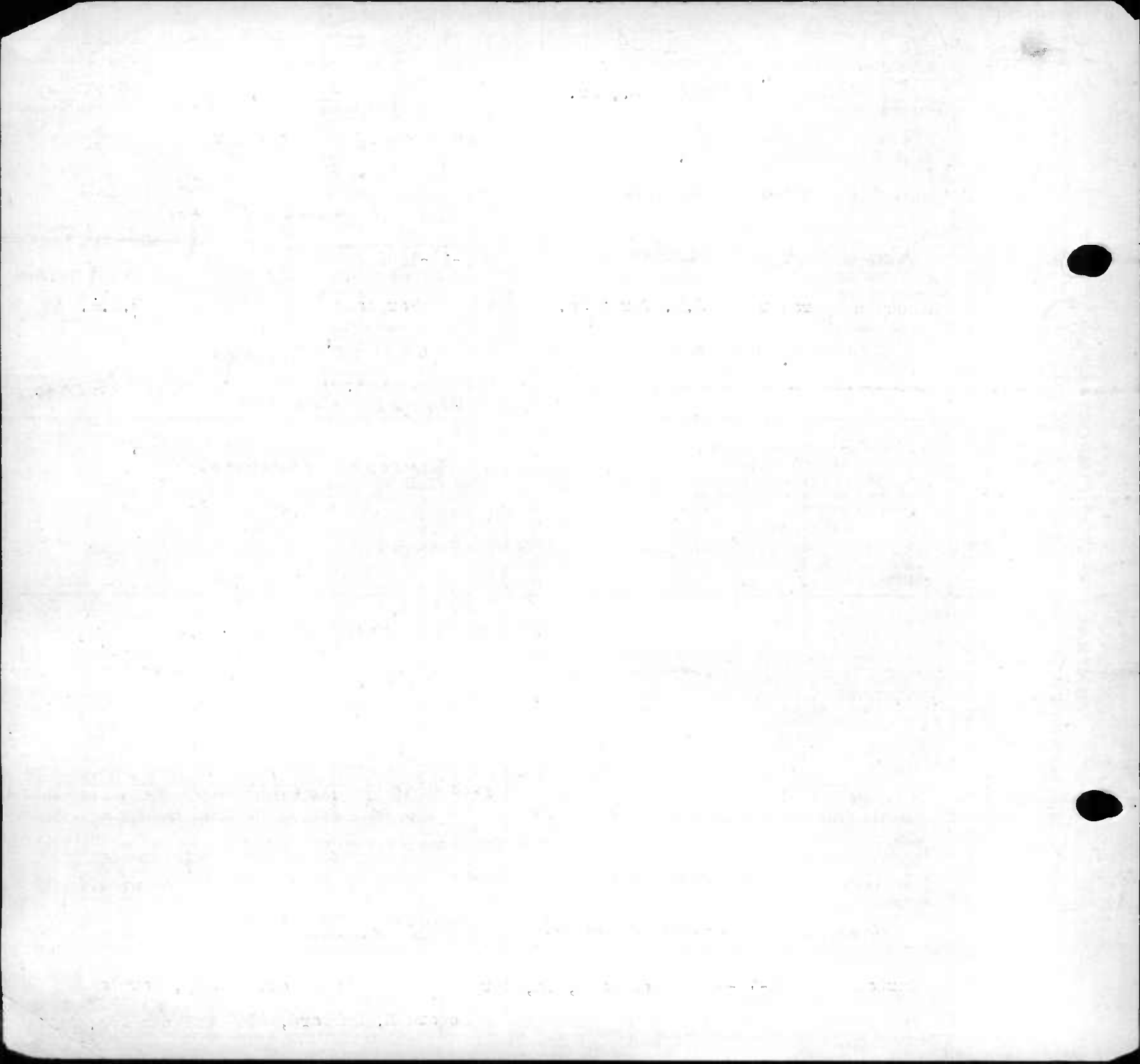
12:10

12:10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
68 1004 CERTIFICATE OF DEATH					REG. NO. 68 1004				
1. NAME OF DECEASED (Type or Print) HAROLD MENTZEL E., Sr.					2. DATE AND HOUR OF DEATH JAN. 22, 1968 9:45 A.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CHURCH HOME HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME HOSPITAL					C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
					E. STREET AND NUMBER 915 ST. CHARLES AVE 53-00				
5. SEX Male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-24-1906	9. AGE (In years last birthday) 61	10. If Under 1 Yr. Months Days		11. If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Linotype Operator			10B. KIND OF BUSINESS OR INDUSTRY J.H. Furst Co.		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GRANT E. MENTZEL					14. MOTHER'S MAIDEN NAME NETTIE M. WILLIAMS				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 215 013030		17. INFORMANT E. VIVIAN MENTZEL			ADDRESS 915 ST. CHARLES	
18. 492X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) PULMONARY EMPHYSEMA					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PULMONARY EMPHYSEMA				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CONGESTIVE HEART FAILURE					(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				
19. DATE OF OPERATION 5-27-1					20. AUTOPSY? (Yes or No) YES				
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. HOW DID INJURY OCCUR?				
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from JAN. 14 19 68 to JAN. 22 19 68 , that (I) (we) lost saw the deceased alive on JAN. 22 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Corazon Z. Vergara MD					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 1-22-68	
23C. PHYSICIAN'S NAME (Type) CORAZON Z. VERGARA, M.D.					23D. ADDRESS CHURCH HOME HOSPITAL 100 N. BROADWAY BALT. MD. 21231				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-26-68		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery			24D. LOCATION Baltimore County, Maryland		
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1968			25B. NAME OF REGISTRAR Robert E. Finkbeiner			25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68 1005

BIRTH NO.

REG. NO.

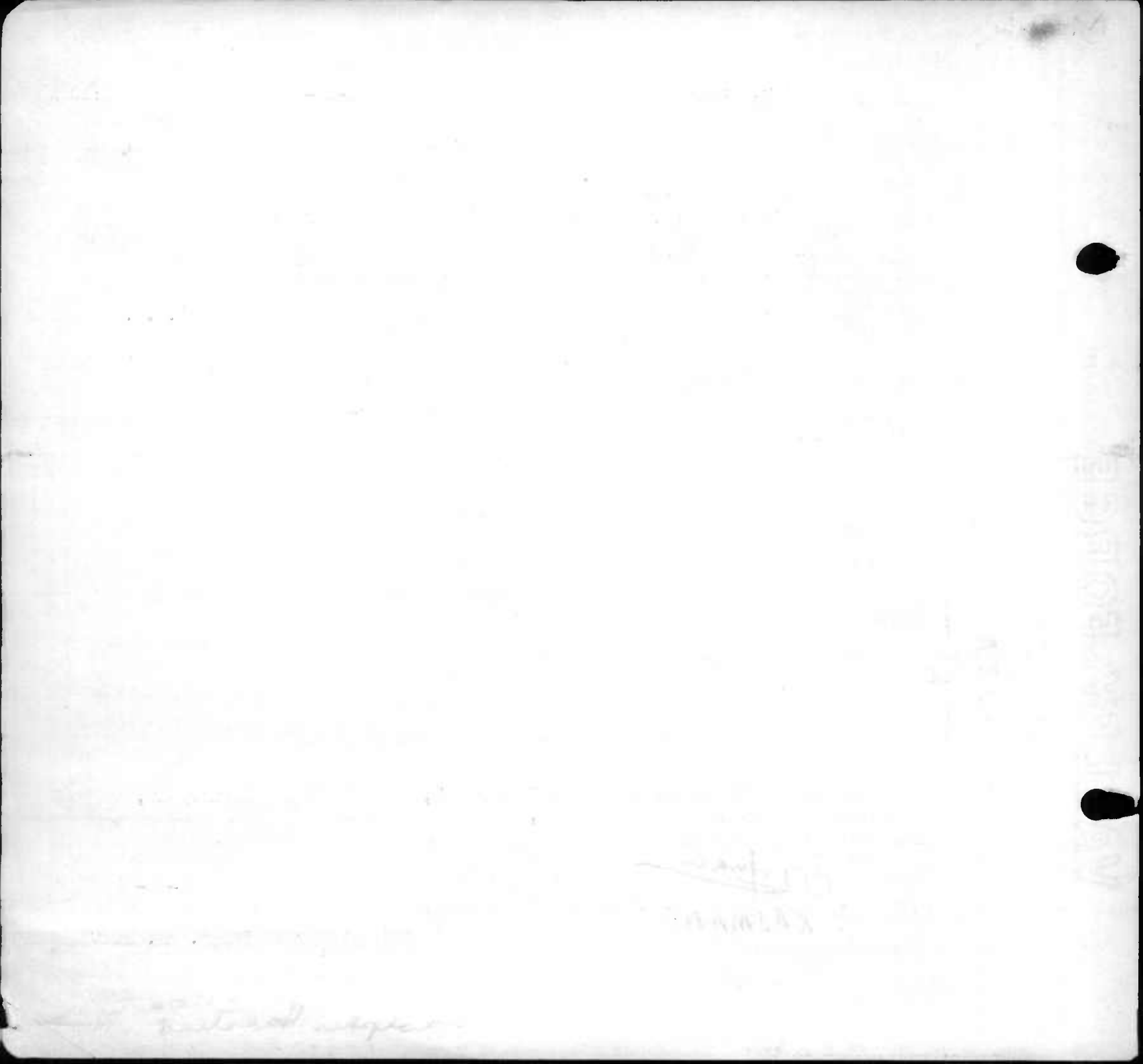
1. NAME OF DECEASED (Type or Print) GOLDIE GARRIS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> January 19, 1968 11:59 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1040 N. Central Avenue (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour January 19, 1968 11:59 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 10-01	
9. DATE OF BIRTH		10. AGE (In years last birthday) 73	
11. BIRTHPLACE (State or foreign country) Norfolk Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laboer		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
13. FATHER'S NAME Unknown		15. MOTHER'S MAIDEN NAME Celia	
19. 412.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/20/68	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/24/68	
24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A A County Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1968		25B. NAME OF REGISTRAR Robert E. Fink	
25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W North Ave	

WAMPELLEY HONORABLE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 68 1006	
BIRTH NO. 68 1006		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) Major, Mollie		1-19-68 6:10 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital Inc. 1514 Division Street Baltimore, Maryland 21217		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write full name and give township) D. STREET ADDRESS (If rural, give location) 1718 Division Street			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH /?	9. AGE (In years lost birthday) 55	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Horace Major-Husband	
18. 485X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Broncho pneumonia (B) Broncheecton's (C)		INTERVAL BETWEEN ONSET AND DEATH Same	
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 19, 1968 to January 19, 1968, that (I) (we) lost saw the deceased olive on January 19, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. J. Manne		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-19-68	
23C. PHYSICIAN'S NAME (Type) RAJMANE		23D. ADDRESS M.D. 1514 Division Street Balto. Md. 21217			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/25/68		24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery	
24D. LOCATION A A County Md		25A. DATE REC'D BY HEALTH DEPT. JAN 25 1968			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR C. J. Manne		25D. ADDRESS 1206 W North	



FUNERAL DIRECTOR: IMPORTANT 2311

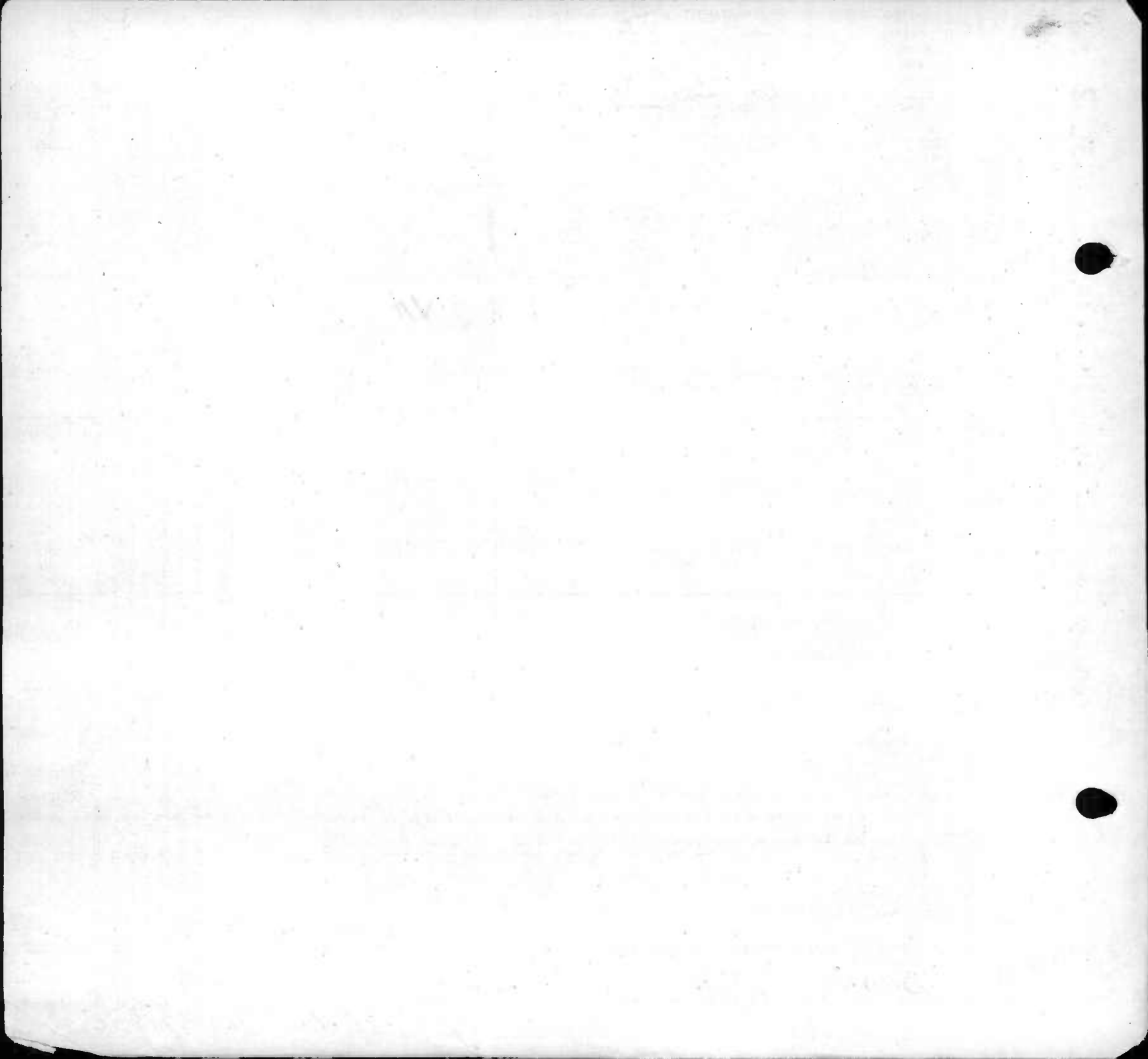
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68 1007

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68 1007

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>William, Edward (Ed.)</i>		2. DATE AND HOUR OF DEATH <i>1-24-68 1:15 AM</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>7-04</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>1022 N. Washington St.</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
5. SEX <i>Male</i>	6. RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-18-95</i>	9. AGE (In years last birthday) <i>73</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Steel Worker</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>VA.</i>	
13. FATHER'S NAME <i>Doc Gilliam</i>		14. MOTHER'S MAIDEN NAME <i>NANNIE</i>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Records (Mary Gilliam)</i>	
18. <i>412.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>443X II</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiac arrest</i> (B) <i>HASCVD</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i> <i>10 years.</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Dudley D. Goulden</i>				23B. DATE SIGNED <i>1/24/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>DUDLEY D. GOULDEN</i>				23D. ADDRESS <i>THE JOHNS HOPKINS HOSPITAL</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>Jan 27/68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt Auburn</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 25 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR <i>Frank E. Eickman</i>	
				ADDRESS <i>11297 Carroll St</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
68 1008 CERTIFICATE OF DEATH					Registered No. 68 1008				
BIRTH NO. 68 1008					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <i>Brevard, Joel</i> (Voel)					2. DATE AND HOUR OF DEATH <i>1/23/1968</i> <i>6:00 P.M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY				
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i> (If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto.</i>				
					D. STREET ADDRESS (If rural, give location) <i>309 N. Arlington Ave.</i>				
5. SEX <i>M</i>	6. RACE <i>N N</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <i>12/25/15</i>	9. AGE (In years last birthday) <i>52</i>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Maintenance Men Gen Contr.</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>KEESHAW CO. S.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>JOHN BREVARD</i>					14. MOTHER'S MAIDEN NAME <i>POLLIE GAITHER</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>					16. SOCIAL SECURITY NO. <i>251-16-2804</i>		17. INFORMANT ADDRESS <i>SAMUEL BREVARD 4712 JUAN HOS AVE</i>		
18. <i>4-31-9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <i>Subarachnoid Hemorrhage</i> DUE TO (B) <i>Intracerebral Hemorrhage</i> DUE TO (C) <i>W.K.W.</i>				
INTERVAL BETWEEN ONSET AND DEATH <i>8 hours</i>									
MEDICAL CERTIFICATION									
331X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>2</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <i>1/23/1968</i> to <i>1/23/1968</i> , that (1) (we) last saw the deceased alive on <i>1/23/1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>[Signature]</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <i>1/23/1968</i>	
23C. PHYSICIAN'S NAME (Type) <i>DR. HARRY F. HOLCOMB, JR.</i>					23D. ADDRESS <i>THE UNION MEMORIAL HOSPITAL</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Removal</i>		24B. DATE		24C. NAME OF CEMETERY or CREMATORY <i>Mt Olivet Church Mechanicsburg C. N. C.</i>		24D. LOCATION (City, town or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 25 1968</i>		25B. NAME OF REGISTRAR <i>[Signature]</i>		25C. FUNERAL DIRECTOR <i>Manhattan & Payne 638 N. GILMAN ST</i>		ADDRESS			

4.4.
B.L.V.
309 N. Arlington Ave
Wash D.C.

Union Memorial Hospital

Police Car. 1000

See Bureau

with - see - Bureau - 1000 - 1000

Subsidiary - 1000 - 1000

in 1000

1000

1000

1000

1
H. 000

68-1009

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-1009

BIRTH NO.		1. NAME OF DECEASED (Type or Print) HENRY C. HOUE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 1 22 68 8:30 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION South Balto. General Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour January 22, 1968 8:30 a.m.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 22-01	
6. SEX Male	7. RACE Colored	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 7-27-1917		10. AGE (In years lost birthday) 50	11. BIRTHPLACE (State or foreign country) Fayetteville, N. C.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		E. STREET AND NUMBER 135 W. Lee St.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Unknown	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes WWII		17. SOCIAL SECURITY NO.		18. INFORMANT Daisy Jackson 731 W. Barre St.	
19. 345-9-E887X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE Subdural hemorrhage DUE TO, OR AS A CONSEQUENCE OF: (B) a fall DUE TO, OR AS A CONSEQUENCE OF: (C) epilepsy, the etiology of which is not certain		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) YES	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 135 W. Lee St.	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 1 8 68 5:30		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? fall at house on concrete	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Edward F. Wilson, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED April 26, 1968					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-26-68		24C. NAME OF CEMETERY or CREMATORY Balto. National	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 25 1968		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR Marshall P. Hayes 638 N. Gilmor St.		25D. ADDRESS			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

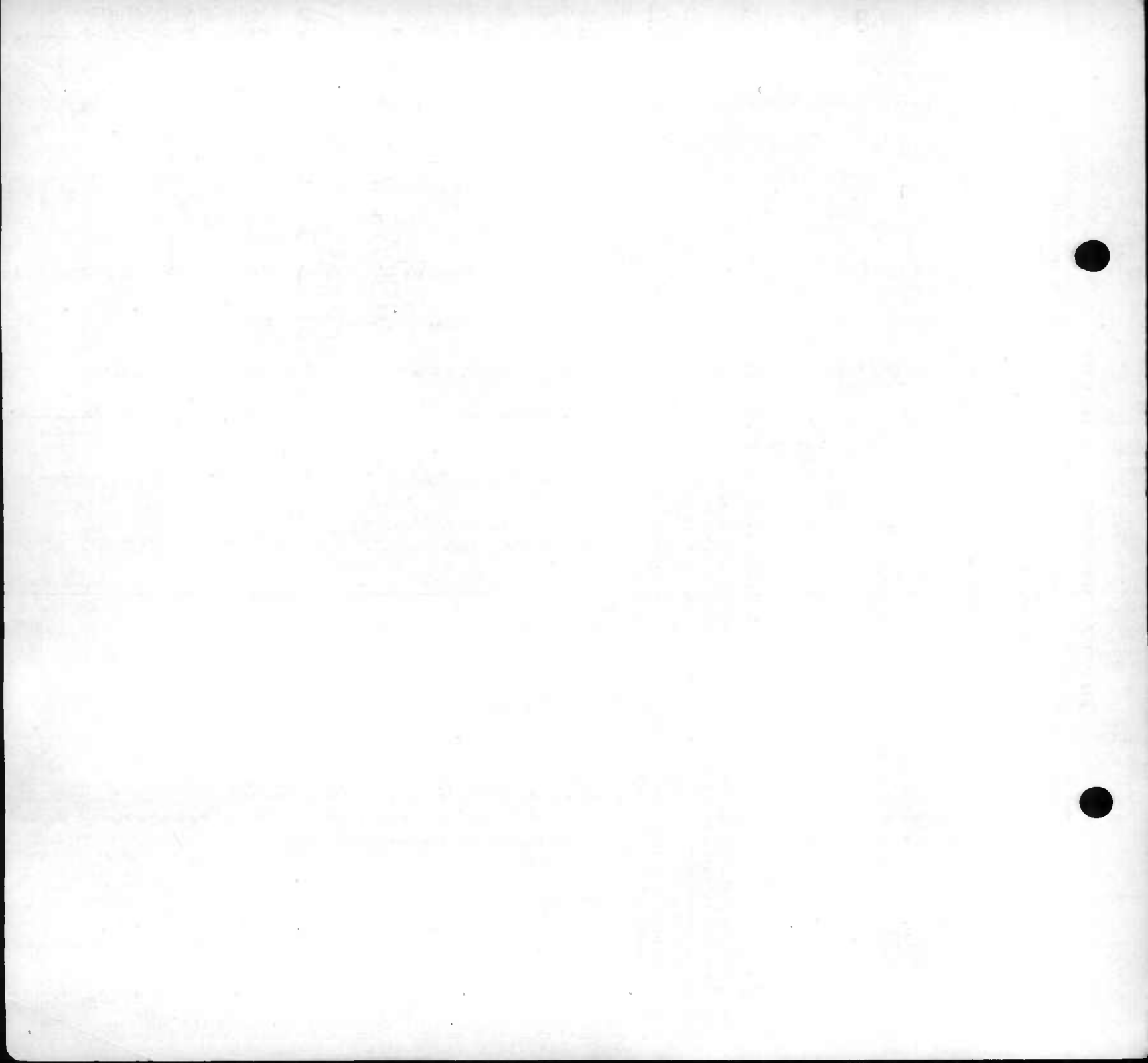
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68 1010	
<div style="display: flex; justify-content: space-between;"> H 6288 1010 1 </div>					
BIRTH NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print)			<div style="display: flex; justify-content: space-between;"> January 21, 1968 6:32 a. M. </div>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
<div style="display: flex;"> <div style="flex: 1;"> FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital 1514 Division Street Baltimore, Maryland </div> <div style="flex: 1;"> (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) </div> </div>			<div style="display: flex;"> <div style="flex: 1;"> A. STATE Maryland </div> <div style="flex: 1;"> B. COUNTY 15-01 </div> </div>		
<div style="display: flex;"> <div style="flex: 1;"> C. CITY OR TOWN Baltimore </div> <div style="flex: 1;"> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> </div> </div>			E. STREET AND NUMBER 1509 Carey Street		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Female	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	3-12-12	55	Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
			Maryland		U. S. A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Thomas GREEN			Mary BROWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
NO			915-18-5602		STANLEY HARRIS - SAME - HUSBAND
18. 427.01			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			congestive heart failure.		
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) _____		
19. DATE OF OPERATION			20A. AUTOPSY? (Yes or No)		
434.1 II			No		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 1-19-68 19 to 1-21-68 19, that (I) (we) last saw the deceased alive on 1-21-68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
<div style="display: flex; align-items: center;"> <div style="margin-left: 10px;"> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> </div> </div>			1-22-68		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
RAJMA IVE			1514 Division Street		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)
Burial		1/25/68	BALTO. NAT'L. Cem.		BALTO. Md.
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 25 1968		R. B. E. Taylor		HEKON FUNERAL HOME 1348 Calhoun St.	

1049113

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68 1011	
<div style="display: flex; justify-content: space-between;"> 28 1011 H 400 BIRTH NO. </div>					
1. NAME OF DECEASED (Type or Print) Hall, Harrison			2. DATE AND HOUR OF DEATH January 20, 1968 7:30 a. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 Provident Hospital 1514 Division Street Baltimore, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 14-03 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2313 Pennsylvania Avenue		
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-4-87	9. AGE (In years last birthday) 70	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md. 12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 220051145	17. INFORMANT ADDRESS Elizabeth Thompson 1627 Calhoun St.		
18. 162-1 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of Lungs. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) </div> <div style="width: 35%; text-align: center;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH </div> </div>					
19. 163X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 19, 1968 to January 20, 1968 , that (I) (we) last saw the deceased alive on January 20, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 1-20-68	
23C. PHYSICIAN'S NAME (Type) (AHSAAN SAEED KHAN)				23D. ADDRESS 1514 Division Street Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1-24-68		Mt. Calvary Cem.	
24D. LOCATION (City, town, or county)		24E. (State)			
Baltimore, Maryland		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1968		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR ADDRESS Kelson Funeral Home 1348 Calhoun St.	



S530

BALTIMORE CITY HEALTH DEPARTMENT

68 1012

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68 1012

BIRTH NO.

1. NAME OF DECEASED (Type or Print) VIOLA Katherine SMITH				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input checked="" type="checkbox"/> January 22, 1968 6:00 P. M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 932 Ellicott Drive				3. DATE PRONOUNCED DEAD Month Day Year Hour January 23, 1968 7:45 A. M.			
5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 16-08							
6. SEX female	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 4-23-13		10. AGE (In years lost birthday) 54		11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Phillip Peters				14. MOTHER'S MAIDEN NAME Jessie Jackson			
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				16. KIND OF BUSINESS OR INDUSTRY			
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no				18. SOCIAL SECURITY NO. 214128497		19. INFORMANT ADDRESS Theodore Peters 923 Ellicott Drive.	
19. CAUSE OF DEATH 412.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
II 422.1 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION 0				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) No							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?							
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?							
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1/23/68							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-26-68		24C. NAME of CEMETERY or CREMATORY Nat'l. Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1968		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS Kelson Funeral Home 1348 Calhoun St.			

RECEIVED

WALTER GORDON

VALLEYVIEW

Walter Gordon

D-655

68 1013 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68 1013

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

CHARLES

DRUMMOND

2. DATE
OF
DEATH

Known ☐
Estimated ☒

Month

Day

Year

Hour

January 16, 1968

9:00 A. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

244 N. Fulton Street

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

January 16, 1968

9:00 A. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS

Baltimore

YES ☒

NO ☐

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

9. DATE OF BIRTH

12/15/44

10. AGE (In years
lost birthday)

23

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

745 Linnard St.

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John L Drummond

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

19. 304.9

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

323X II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐

NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion

resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/16/68

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JAN 25 1968

W. U. Spitz

1712 W. W. K. Ave

Baltimore Md.

12/15/44

John L. Drummond
1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68 1014				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68 1014	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) JULIA Z. COOPER			
2. DATE AND HOUR OF DEATH JAN. 23 1968 1:30 P.				M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 3600 Springdale Ave				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
D. STREET ADDRESS (If rural, give location) 3600 SPRINGDALE AVE.				15-38			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH JAN. 6, 1881	9. AGE (In years last birthday) 87	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. 433.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) Cerebral thrombosis				INTERVAL BETWEEN ONSET AND DEATH 1 mo.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO (C)			
332X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic cardiovascular disease 5 years							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan. 20 1964 to Jan. 23 1968 , that (I) (we) last saw the deceased alive on Jan. 22 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Abraham B. Hurwitz				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Jan. 23, 1968	
23C. PHYSICIAN'S NAME (Type) ABRAHAM B. HURWITZ				23D. ADDRESS 7501 Liberty Road, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1/28/68		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) (State) Sparks Hill Md	
25A. DATE RECEIVED BY HEALTH DEPT. JAN 23 1968		25B. NAME OF REGISTRAR Opal E. Sanders		25C. FUNERAL DIRECTOR Lin F. Enroll		ADDRESS	

24 July 1958

Jan 23 1958

Baltimore, Md.

1501 Liberty Road

ABRAHAM B. HURWITZ
Champion B. Hurwitz

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

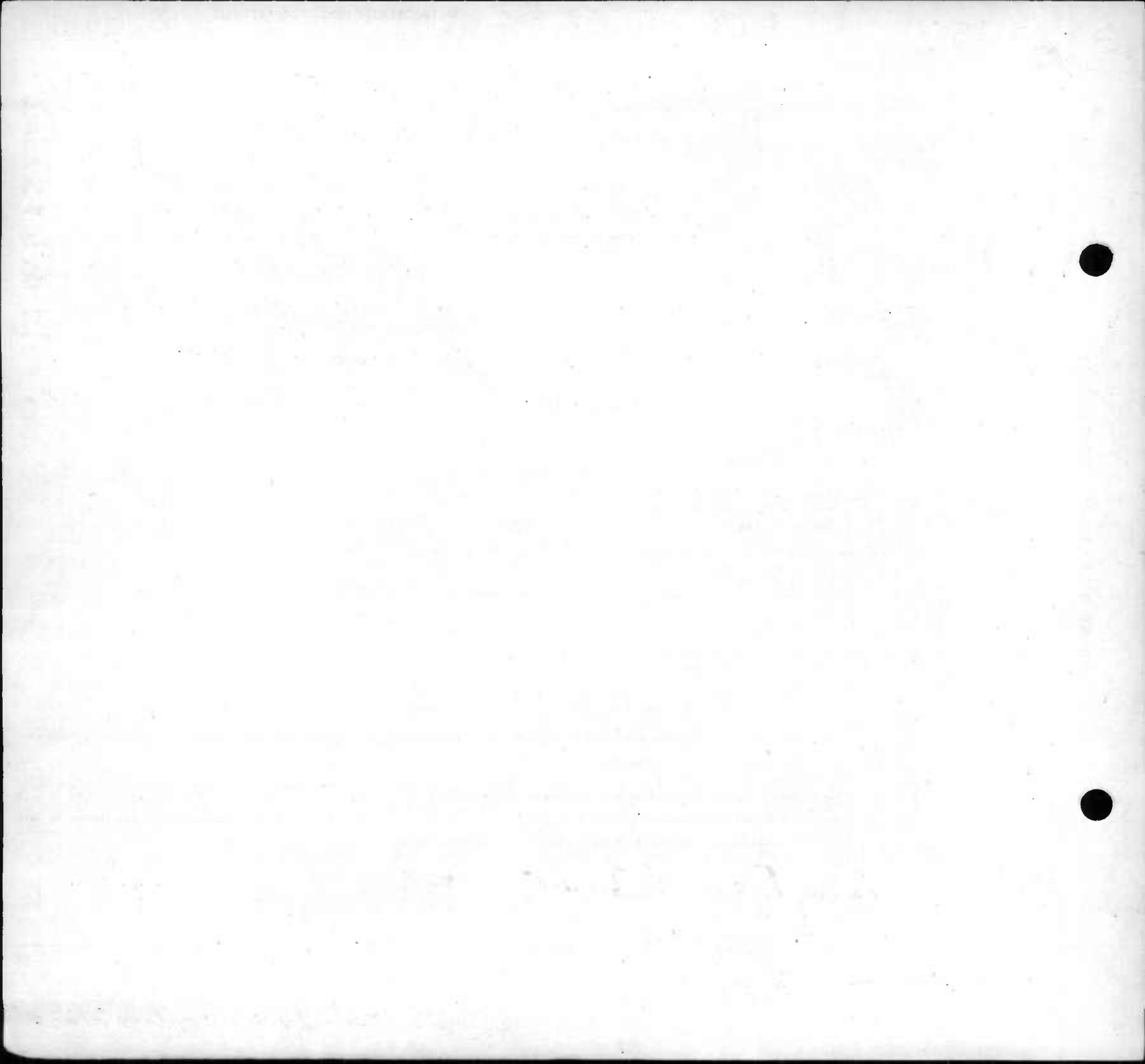
68 1015

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68 1015

BIRTH NO.		1. NAME OF DECEASED (Type or Print) HARRY THOMAS STANSBURY		2. DATE AND HOUR OF DEATH MONDAY, 22, 1968 4:50 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 23-01		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 1330 HANOVER ST (NEVER MARRIED)		E. STREET AND NUMBER 1330 HANOVER ST		F. ZIP CODE 21230	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 30, 1880		9. AGE (In years last birthday) 87
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. GLASS Blower		10B. KIND OF BUSINESS OR INDUSTRY Bottle Glass Mfg.		11. BIRTHPLACE (State or foreign country) BALTIMORE, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Robert STANSBURY		14. MOTHER'S MAIDEN NAME Amelia PURPLE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-22-09380		17. INFORMANT Myrtle A. Smith (Niece) ADDRESS Same	
18. 410.9 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Immediate	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		Coronary Aclusion			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		?	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Arterio Slerotic Heart Disease			
(C).....					
420.1 II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January, 10 19 68 to January 15, 19 68 , that (I) (we) last saw the deceased alive on January 15, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harry Deibel M.D. DEGREE MD				23B. DATE SIGNED 1-24- 1968	
23C. PHYSICIAN'S NAME (Type) Dr. Harry Deibel DEGREE MD				23D. ADDRESS 1226 S. Hanover St.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JAN. 25-1968		24C. NAME OF CEMETERY OR CREMATORY Mt. OLivet Cemetery	
24D. LOCATION (City, town, or county) BALTIMORE, Md.		24E. (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR CURTIS E. EVANS ADDRESS 1400 S. CHARLES 21230	



68 1016

BALTIMORE CITY HEALTH DEPARTMENT

68 1016

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

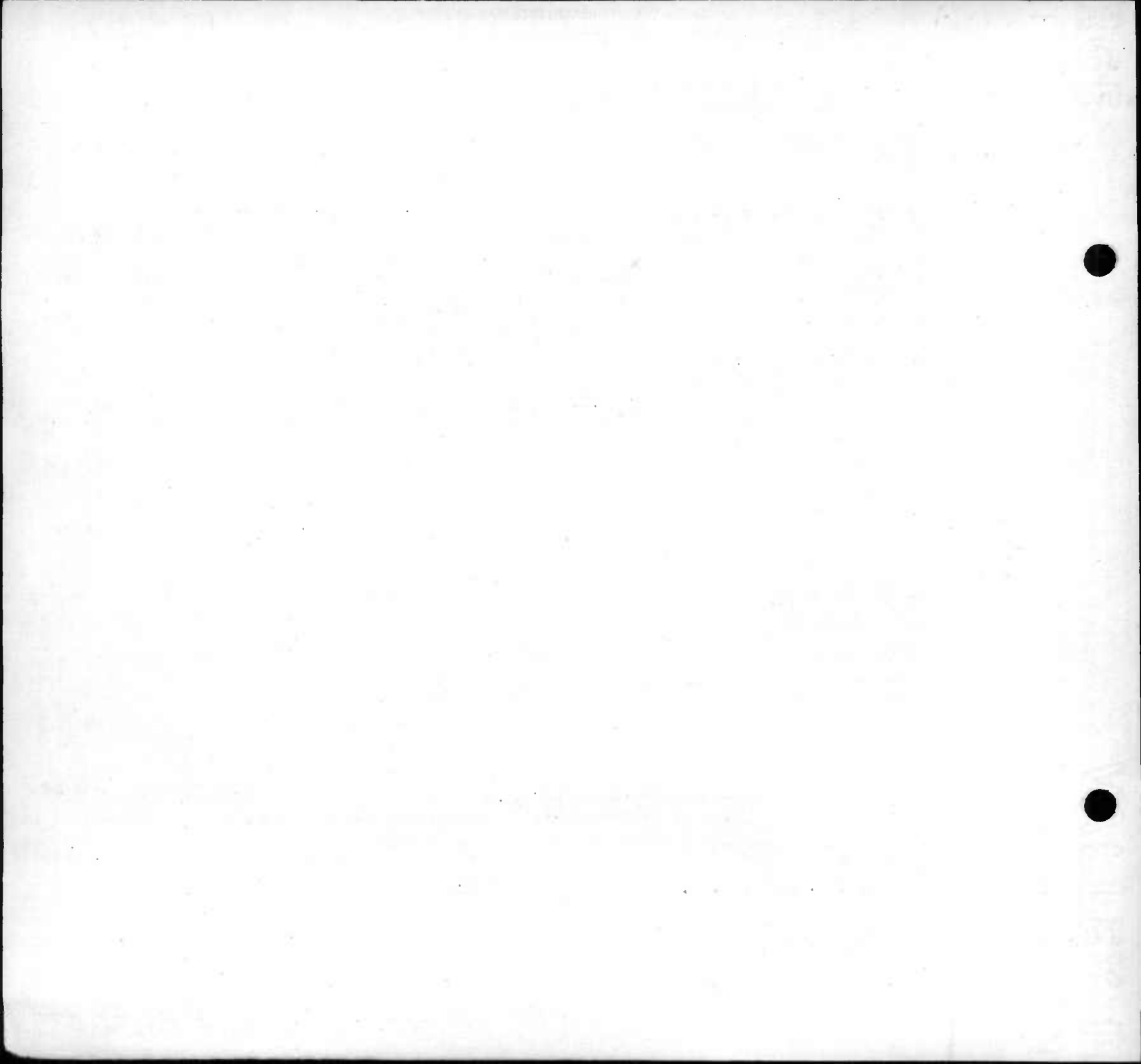
BIRTH NO.

1. NAME OF DECEASED (Type or Print) GEORGE S NEWLIN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> January 24, 1968 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour January 24, 1968 6:25 P.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Philadelphia	
9. DATE OF BIRTH 7/7/1887		10. AGE (In years lost birthday) 80	
11. BIRTHPLACE (State or foreign country) Phila. Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James A. Newlin		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
15. MOTHER'S MAIDEN NAME Anna Gardiner		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 176-18-0190		18. INFORMANT Mary Newlin ADDRESS 1519 Fountain St. Phila. Pa.	
19. 441.01		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Hemopericardium DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) Dissecting aneurysm of aorta DUE TO, OR AS A CONSEQUENCE OF:	
(C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) (Partial) Yes	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED January 25, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/30/68	
24C. NAME OF CEMETERY or CREMATORY Eden Cemetery		24D. LOCATION (City, town, or county) (State) Philadelphia Pa.	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1968		25B. NAME OF REGISTRAR Robert E. Fairbanks	
25C. FUNERAL DIRECTOR Herbert E. Natter		ADDRESS 3035 W. North Ave	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68 1017	
68 1017				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MARY M. WITT (WITKOWSKI)			
2. DATE AND HOUR OF DEATH JAN 22, 1968		M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 2428 FOSTER AVE.			A. STATE MD. B. COUNTY 1-03		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 2428 FOSTER AVE.					
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 21, 1881	9. AGE (In years last birthday) 86	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME MARTIN NOWAK		14. MOTHER'S MAIDEN NAME EVA.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-54-7108		17. INFORMANT ADDRESS MR. Joseph Witt 2428 Foster Ave.	
18. 440.91		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Edema of the Lungs		3 days	
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(B) Atherosclerotic vascular disease DUE TO, OR AS A CONSEQUENCE OF:		About 10 Years	
ANTECEDENT CAUSES		(C) Old age			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
450.0 II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 19 66 to January 22, 19 68 , that (I) (we) last saw the deceased alive on January 19, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ernest G. Marr, M. D.			Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/25/68
23C. PHYSICIAN'S NAME (Type) Ernest G. Marr, M.D.			23D. ADDRESS 516 Cathedral St., Baltimore, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE 1/26/68	24C. NAME OF CEMETERY OR CREMATORY Holy Rosary Cem.	24D. LOCATION (City, town, or county) (State) BALTIMORE MD.		
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1968	25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS B. DABROWSKI 288 F. BALTO. ST.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M-620		68 1018		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68 1018	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) Mildred E. Myers				1-23-68 11:07 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 St. Agnes Hospital				A. STATE Maryland B. COUNTY Anne Arundel			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Jessup 20794 52-00			
				D. STREET ADDRESS (If rural, give location) 28 Sharewood Dr. Sharewood			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED Married	8. DATE OF BIRTH 8/21/12	9. AGE (In years last birthday) 55	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Norman Penn				14. MOTHER'S MAIDEN NAME Anna Coburn			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 579-32-6743		17. INFORMANT Mr. Ralph V. Myers		ADDRESS (Same)	
18. 431.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Cerebral Vascular Accident 2 hours ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebral Hemorrhage Hypertension				INTERVAL BETWEEN ONSET AND DEATH			
331X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1-23-68 to 1968 , that (I) (we) last saw the deceased alive on 1-23-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Leonard J. Ruck, Inc.				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1-23-68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS St. Agnes Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/27/68.		24C. NAME of CEMETERY or CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) Glenburnie, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1968		25B. NAME OF REGISTRAR Robert E. Fairbanks		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21211			

Wm. L. Garrison

200-1-2-1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
E-165 68 1019 CERTIFICATE OF DEATH					REG. NO. 68 1019									
BIRTH NO.					1. NAME OF DECEASED (Type or Print) <u>EVERING, GEORGE A</u>					2. DATE AND HOUR OF DEATH <u>Jan 24, 1968</u> <u>1:00 A.M.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE CITY</u>					C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 THE JOHNS HOPKINS HOSPITAL</u>					E. STREET AND NUMBER <u>5424 REMMELL AVE</u>					21205 <u>27-34</u>				
5. SEX <u>MALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-24-79</u>		9. AGE (In years last birthday) <u>88</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during last year of life, even if retired) <u>Chief Distributor</u>					10B. KIND OF BUSINESS OR INDUSTRY <u>Beth. Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>CHRISTIAN EVERING</u>					14. MOTHER'S MAIDEN NAME <u>MARGARET Schuler</u>									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>213-07-7997</u>		17. INFORMANT <u>Mrs Catherine Evering</u>			ADDRESS <u>Same</u>				
18. <u>412.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac arrest 2° respiratory arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>Pulmonary edema</u> <u>Massive CHF 2° ASCVD</u>					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION <u>422.1 II</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <u>yes</u>				
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (1) (this hospital) attended the deceased from <u>Jan 22</u> 19 <u>68</u> to <u>Jan 24</u> 19 <u>68</u> , that (1) (we) last saw the deceased alive on <u>Jan 24</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <u>K.E. Gilman, M.D.</u>					23B. DATE SIGNED <u>Jan. 24, 1968</u>									
23C. PHYSICIAN'S NAME (Type) <u>R.E. GILMON</u>					23D. ADDRESS <u>Johns Hopkins Hospital</u>									
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					24B. DATE <u>1/27/68</u>					24C. NAME of CEMETERY or CREMATORY <u>Parkwood</u>				
24D. LOCATION <u>Baltimore, Maryland</u>					25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1968</u>					25B. NAME OF REGISTRAR <u>Robert E. ...</u>				
25C. FUNERAL DIRECTOR <u>Leonard J Ruck Inc</u>					25D. ADDRESS <u>5305 Harford Rd</u>									

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-612		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68 1020	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Pauline F. Gervasi</i>		2. DATE AND HOUR OF DEATH <i>1/24/68. 9:55 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>Balt. City</i>		5. AGE (In years, months, days, hours, minutes) <i>79</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>44 Union Memorial Hosp.</i>		C. CITY OR TOWN <i>Balt.</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>3003 Mayfield Ave</i>		6. OATE OF BIRTH <i>7/02/88</i>		7. AGE (In years, months, days, hours, minutes) <i>79</i>	
8. SEX <i>F</i>		9. RACE <i>W</i>		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		12. KIND OF BUSINESS OR INDUSTRY		13. BIRTHPLACE (State or foreign country) <i>Italy</i>	
14. FATHER'S NAME <i>Rando 220</i>		15. MOTHER'S MAIDEN NAME <i>Unknown</i>		16. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
17. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		18. SOCIAL SECURITY NO. <i>218-03-3193</i>		19. INFORMANT <i>Mrs. Jennie Crocetti</i> ADDRESS <i>1151 Deanwood Rd. Balt. Md.</i>	
20. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Acute myocardial infarction</i>		21. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic coronary disease</i>		22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>W.K.C.</i>	
23. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		25. MEDICAL CERTIFICATION	
26. DATE OF OPERATION <i>420.1</i>		27. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>II</i>		28. AUTOPSY? (Yes or No) <i>YES</i>	
29. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		30. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		31. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
32. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		33. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		34. HOW DID INJURY OCCUR?	
35. I certify that (I) (this hospital) attended the deceased from <i>1/20/68</i> to <i>1/24/68</i> , that (I) (we) last saw the deceased alive on <i>1/24/68</i> and that (my) (our) opinion death occurred on the date and hour from the causes stated above. (I) (We) (did) (did not) view the body after death.		36. SIGNATURE <i>DR. B. J. WECKESSER</i>		37. DATE SIGNED <i>1/24/68</i>	
38. PHYSICIAN'S NAME (Type) <i>DR. B. J. WECKESSER</i>		39. ADDRESS <i>THE UNION MEMORIAL HOSPITAL</i>		40. LOCATION <i>Baltimore, Md.</i>	
41. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		42. DATE <i>1/29/68</i>		43. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cemetery</i>	
44. DATE REC'D BY HEALTH DEPT. <i>JAN 25 1968</i>		45. NAME OF REGISTRAR <i>Robert E. Taylor</i>		46. FUNERAL DIRECTOR <i>Leona rd J. Ruck, Inc. Balto. Md. 21214</i>	

11/11

Mr. E. J. ...
3003 Mayfield Ave.
1/23/88
I call

Mr. E. J. ...
3003 Mayfield Ave.

F
W
X
Rando 5-50

Mr. E. J. ...
3003 Mayfield Ave.
1/23/88
I call

1/23/88
1/23/88
1/23/88

1/23/88
1/23/88
1/23/88

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-450		68 1021		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68 1021	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) CALLAHAN EDWARD				2. DATE AND HOUR OF DEATH 1-23-68 10 p.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 47 The Union Memorial Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3403 University place			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 11-16-1899	9. AGE (In years last birthday) 68 y.	10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed				10B. KIND OF BUSINESS OR INDUSTRY Lab. Supply		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME EDWARD J. CALLAHAN			
14. MOTHER'S MARDEN NAME EDITH RAPNUM				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI			
16. SOCIAL SECURITY NO. 216-30-1541				17. INFORMANT JEANETTE C. CALLAHAN			
18. ADDRESS SAME				19. CAUSE OF DEATH Infarctal hemorrhage - subarachnoid extension R Acute bronchopneumonia			
20. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 331X II				21. INTERVAL BETWEEN ONSET AND DEATH 2 wks			
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				23. MEDICAL CERTIFICATION			
24. DATE OF OPERATION 2		25. CONDITION FOR WHICH OPERATION WAS PERFORMED		26. AUTOPSY? (Yes or No) Yes		27. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
28. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		29. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		30. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		31. HOW DID INJURY OCCUR?	
32. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		33. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		34. DATE SIGNED 1-14-1968		35. DATE SIGNED 1-23-1968	
36. I certify that (I) (this hospital) attended the deceased from 1-14-1968 to 1-23-1968 , that (I) (we) last saw the deceased alive on 1-23-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				37. SIGNATURE Darwish M. Nazza			
38. PHYSICIAN'S NAME (Type) Darwish M. Nazza				39. ADDRESS The Union Memorial Hospital			
40. BURIAL CREMATION, REMOVAL (Specify) Burial		41. DATE 1-26-68		42. NAME OF CEMETERY OR CREMATORY New Cathedral		43. LOCATION (City, town, or county) (State) Balto. Md.	
44. DATE REC'D BY HEALTH DEPT. JAN 25 1968		45. NAME OF REGISTRAR R. E. Jenkins		46. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		47. ADDRESS 4905 York Rd.	

Spent the afternoon
in the garden
and the evening
at home
for

50-13-59

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-120		68 1022		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68 1022	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>Laura Gibbs</u>			
2. DATE AND HOUR OF DEATH <u>1/23/68</u> <u>12³⁰</u> <u>A</u> M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u> <u>BALTIMORE CITY HOSPITALS</u> <u>4940 EASTERN AVENUE</u> <u>BALTIMORE, MARYLAND 21224</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>904 NORTH CENTRAL AVENUE</u> <u>21202</u>			
5. SEX <u>FEMALE</u>		6. RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-23-06</u>	
9. AGE (In years last birthday) <u>61</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Custodian</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN GIBBS</u>				14. MOTHER'S MAIDEN NAME <u>ROSETTA TYLER</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>RECORDS: BCH- 4940 Eastern Avenue 21224</u>	
18. <u>250.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>260X II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Pulmonary Abscess - PDA.</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Prolonged Hypoglycemia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Diabetes Mellitus & Insulin Reaction ± 2 wks</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Urinary Tract Infection & Septicemia 3 wks</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4d</u>	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>9/8/67</u> <u>11/16/67</u> 19 to <u>1/23</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1/23</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>John R. Sharp MD</u>				23B. DATE SIGNED <u>1/23/68</u>		23C. PHYSICIAN'S NAME (Type) <u>John R. Sharp</u>	
23D. ADDRESS <u>Balt. City Hosp</u>				23E. FUNDING DIRECTOR ADDRESS <u>Joseph B. Locks Jr 1304 N. Central Ave</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1/27/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Calvary</u>		24D. LOCATION (City, town, or county) (State) <u>A. A. County, Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1968</u>				25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>			

10

60-50-2

6 11

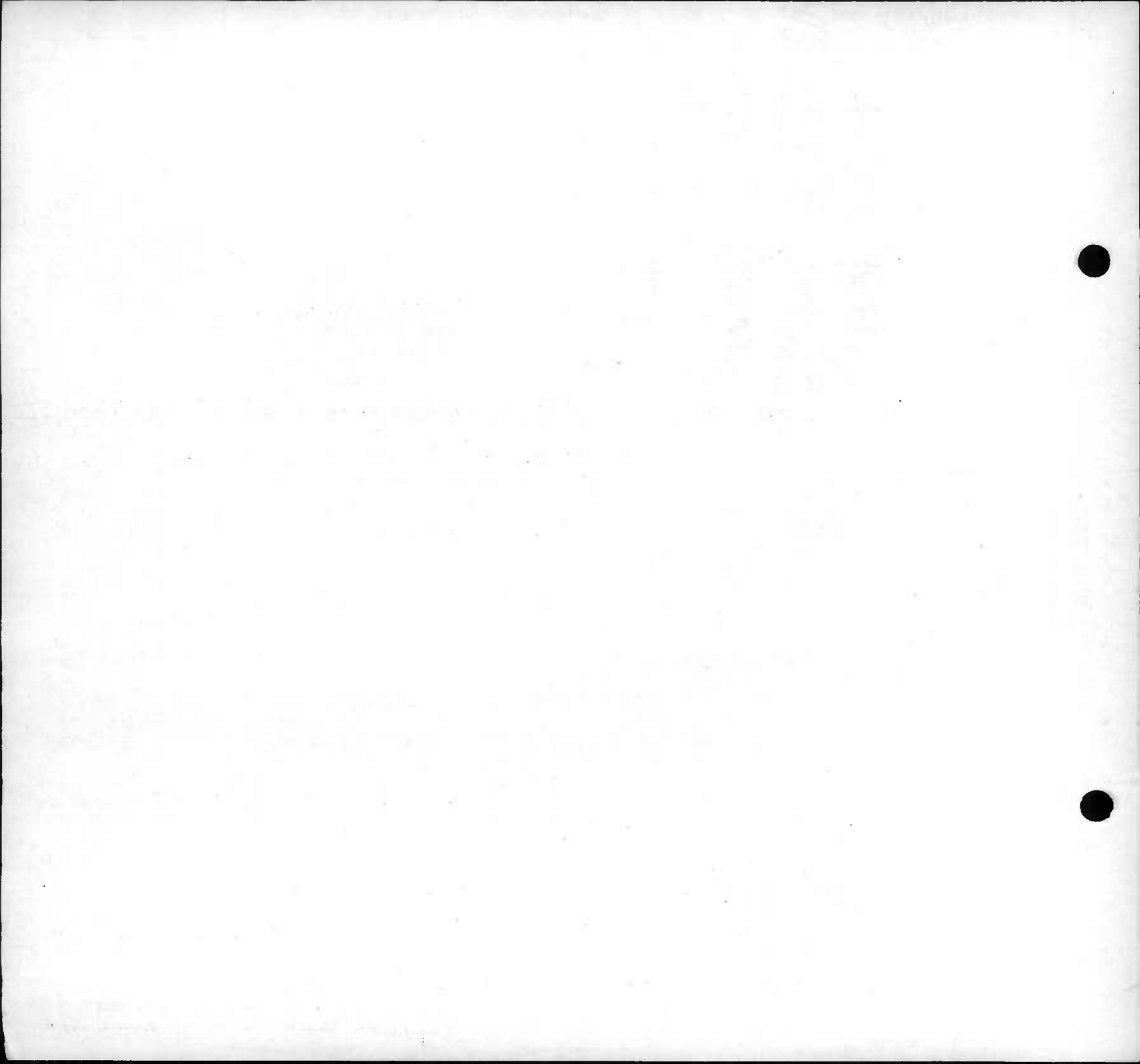
11

James H. Smith
1871-1872

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68 1023	
L-563 68 1023				BIRTH NO.		
1. NAME OF DECEASED (Type or Print) <i>Leonard John H. Sr.</i>				2. DATE AND HOUR OF DEATH <i>1-24-68 10:30 P.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>20-05</i>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>34 Bon Secours Hosp.</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
				E. STREET AND NUMBER <i>540 S. Bentallou Street #23</i>		
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>6-2-89</i>	9. AGE (In years lost birthday) <i>78</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired ICEMAN ICE DELIVERY</i>				11. BIRTHPLACE (State or foreign country) <i>BALTO. Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Samuel Leonard</i>				14. MOTHER'S MAIDEN NAME <i>Sally Hurdle</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No None</i>				16. SOCIAL SECURITY NO. <i>216-07-99024</i>		17. INFORMANT <i>John Leonard Jr. 540 S. Bentallou St.</i>
18. <i>412.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Arteriosclerotic Cardiovascular disease</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <i>Ventral hernia</i>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Indefinite</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>4 years</i> (C).....		
MEDICAL CERTIFICATION						
19. DATE OF OPERATION <i>422.1 II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>0</i>						
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <i>Jan. 23 1968</i> to <i>Jan. 24 1968</i> , that (I) (we) last saw the deceased alive on <i>Jan. 24 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE <i>Nam Dohlfang M.D.</i>				23B. DATE SIGNED <i>Jan 24, 1968</i>		
23C. PHYSICIAN'S NAME (Type) <i>NAM DOH YANG M.D.</i>				23D. ADDRESS <i>Bon Secours Hospital, Balto, Md.</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>1-29-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>NEW CATHEDRAL</i>		24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MD.</i>
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 25 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>GEORGE L. EMMERSON FUNERAL HOME</i> <i>1101 N. Miller 2101 Sudwick Ave.</i>		



B-650

68 1024

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68 1024

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

BRADLEY BROWN

2. DATE OF DEATH

Known ☒ Estimated ☐

Month

Day

Year

Hour

1

22

68

1:40p M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

31

City Hospital

3. DATE PRONOUNCED DEAD

January 22

1968

1:40 p.m.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Balto

6. SEX

Male

7. RACE

White

8. MARRIED

☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

10. AGE (In years last birthday)

32

If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

2115 Southhorn Rd.

Southhorn, Road

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William Henry Brown

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Plumber

14B. KIND OF BUSINESS OR INDUSTRY

Plumbing Cont.

15. MOTHER'S MAIDEN NAME

Bessie Bradley

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

217-30-7465

18. INFORMANT

Linthicum, Md.

Kenneth Trapp, 624 N. Hammonds Ferry Rd.

E81510

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Multiple injuries
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

E8194 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Eastern Blvd 10ft. E of Woodward Drive

22D. TIME OF INJURY (APPROX.)

1 21 68 2:45a

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject driver in auto - fixed object col.

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 22, 1968

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

25 Jan 68

24C. NAME OF CEMETERY or CREMATORY

Maedowridge Memorial

24D. LOCATION

(City, town, or county)

(State)

Elkridge, Howard Co., Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 25 1968

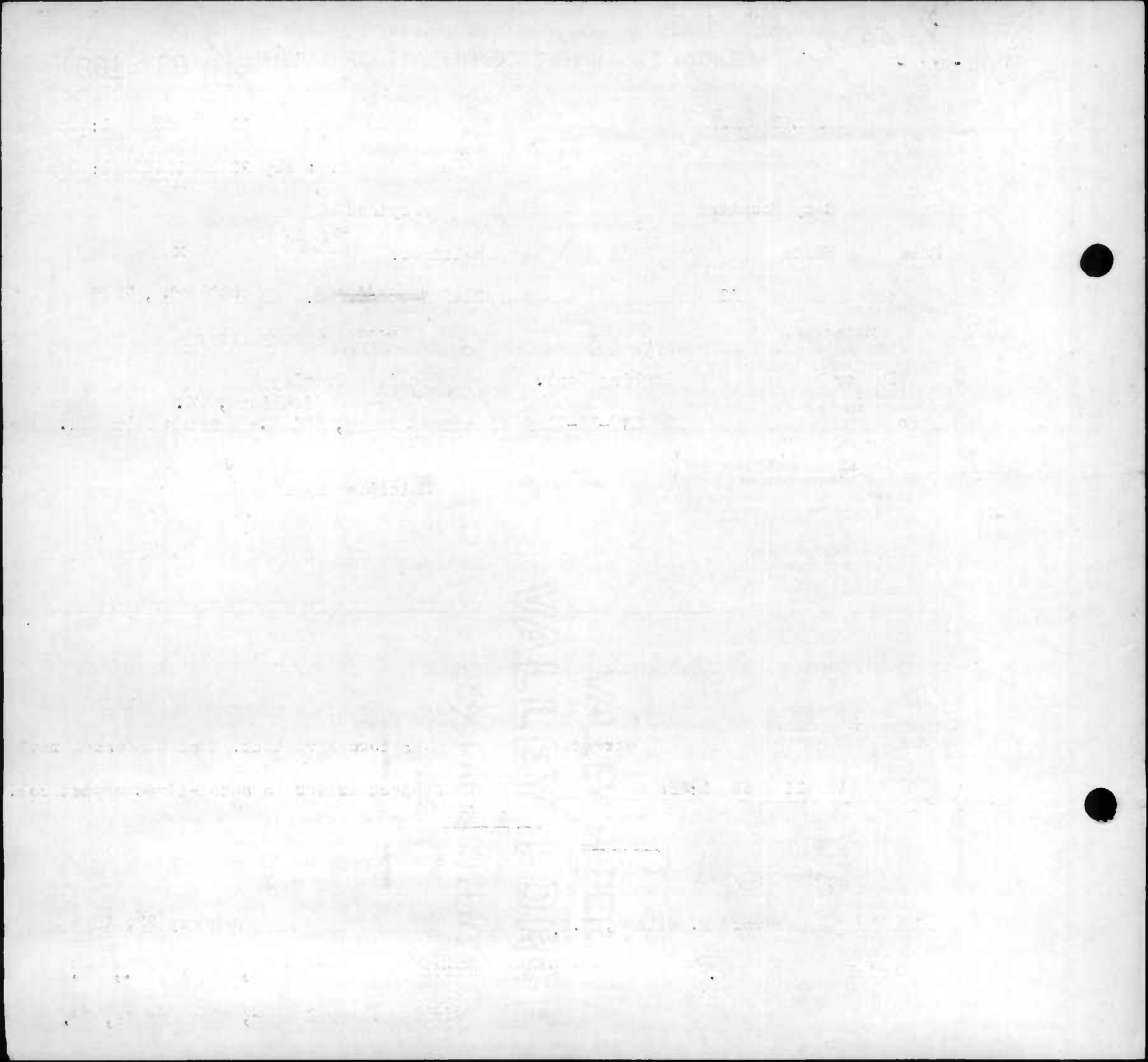
25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

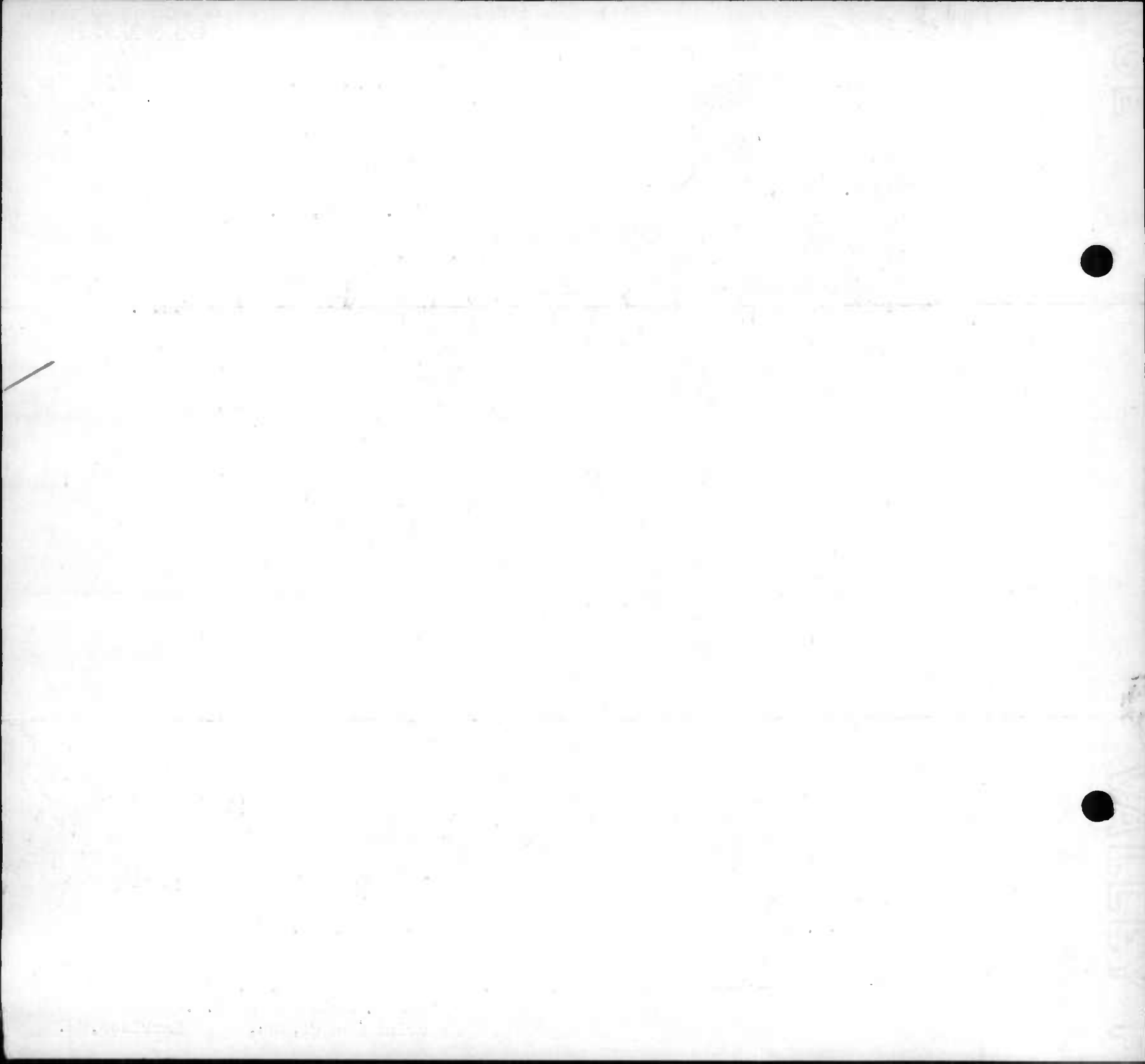
Kirkley Funeral Home, Glen Burnie, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

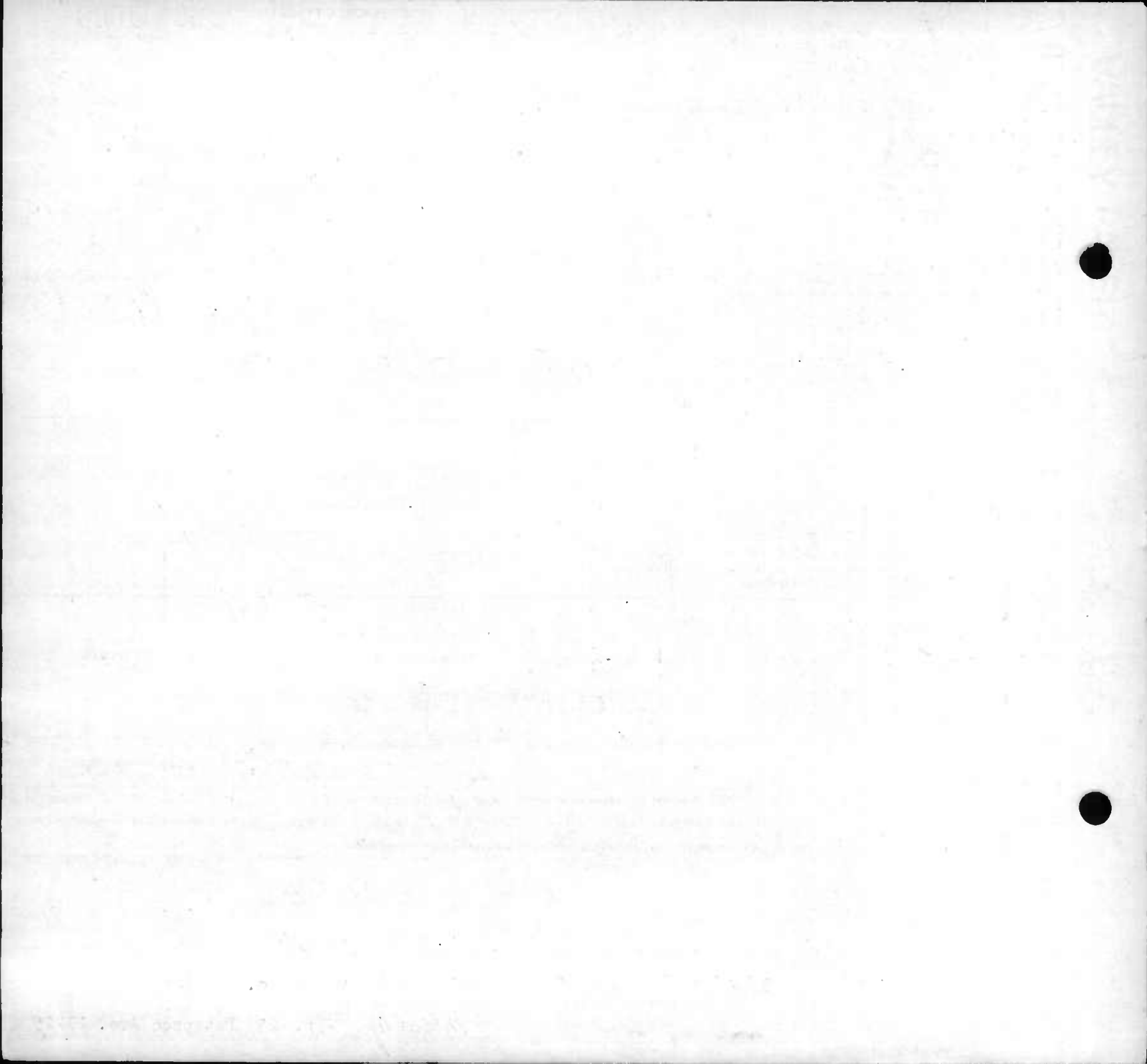
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68 1025
R-323		68 1025	CERTIFICATE OF DEATH	
BIRTH NO.				
1. NAME OF DECEASED (Type or Print) Rose Rotkowitz			2. DATE AND HOUR OF DEATH Jan. 23rd. 1968 8/30 a M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 3813 W. Rogers, Ave			C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
			E. STREET AND NUMBER 3813 W. Rogers, Ave.	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 15th. 1885	9. AGE (In years last birthday) 82
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Russia	
13. FATHER'S NAME Zalman			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO.	17. INFORMANT Harry Levine 3520 Autumn, Drive
18. 412.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH Interdience C & D (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 25 yr				
19. 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 19 46 to Jan 23 19 68 and that (I) (we) lost saw the deceased alive on Jan 23 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE [Signature]			23B. DATE SIGNED 1-23-68	
23C. PHYSICIAN'S NAME (Type) Jos. B. Gross			23D. ADDRESS 6911 Park Hts. Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-24-68		24C. NAME OF CEMETERY or CREMATORY Mogen Abraham Cem.
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Sylvan S. Lewis & Son
				ADDRESS P.O. Box 65 Memorial Chapel, Inc. Garrison, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

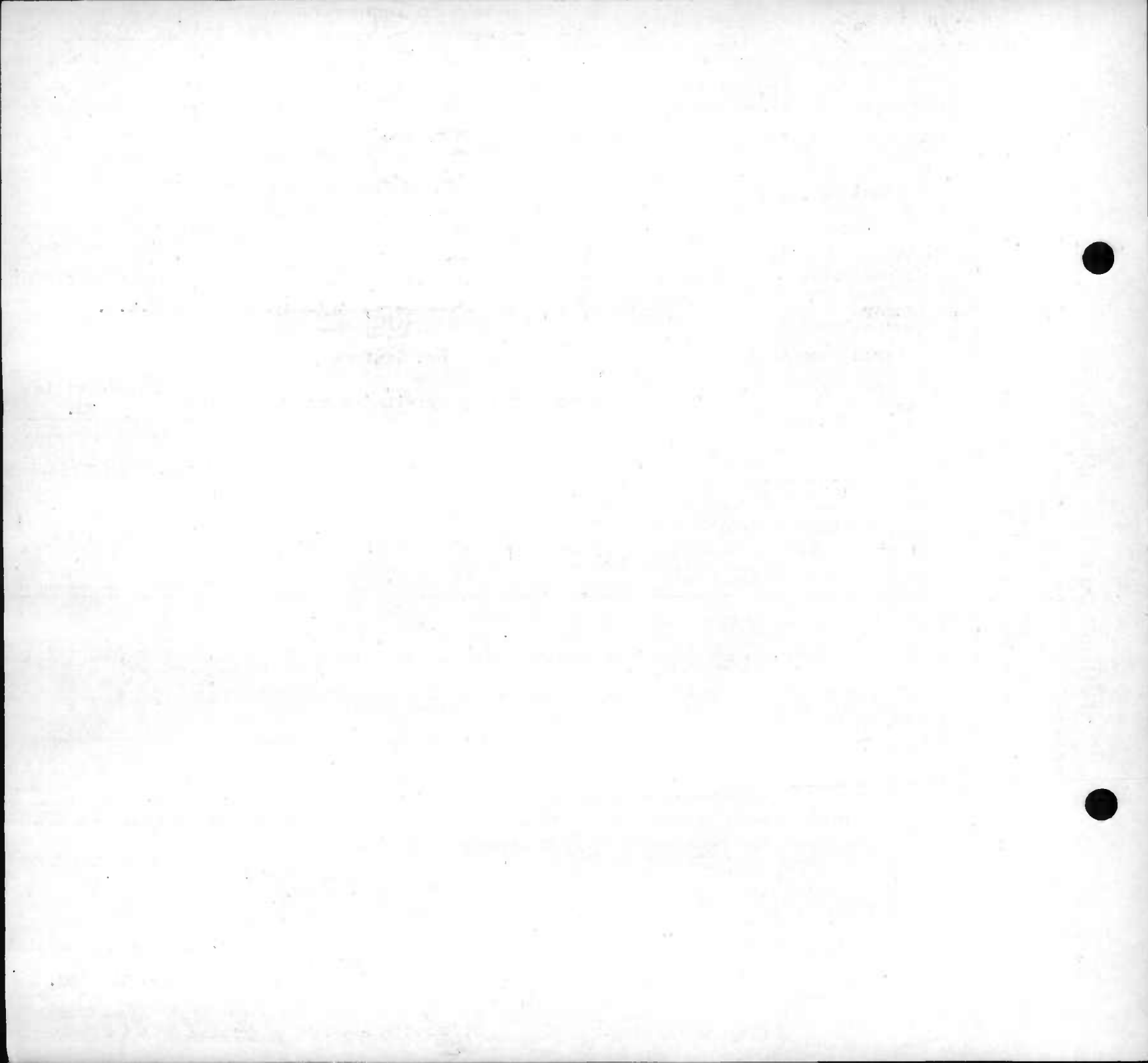
BALTIMORE CITY HEALTH DEPARTMENT										REG. NO. 68 1026	
T-610 68 1026										BIRTH NO.	
1. NAME OF DECEASED (Type or Print) <i>TRIPP, GEORGIA Belle</i>					2. DATE AND HOUR OF DEATH <i>1-21-68 10²⁰ M.</i>						
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>27-18</i>						
FULL NAME OF HOSPITAL OR INSTITUTION <i>42 SINAI HOSPITAL OF BALTIMORE Inc.</i>					C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
E. STREET AND NUMBER <i>5212 WILTON HATS AVE 21215</i>											
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10/7/73</i>	9. AGE (In years lost birthday) <i>94</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>					10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>W. Va. (Clarksburg)</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		
13. FATHER'S NAME <i>George W. Morgan</i>					14. MOTHER'S MAIDEN NAME <i>Ida Combs</i>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Arteriosclerotic cardiovascular disease</i>					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>UNKNOWN Disease</i> <i>FRACTURED PELVIS</i> (B) <i>Compound Fracture of Left Hip</i> (C) <i>Fracture of Left Hip</i> <i>HEART FAILURE</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (At stating the UNDERLYING CONDITION last.) <i>422.1 II</i>					OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A)						
19A. DATE OF OPERATION <i>1-18-68</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Fracture of Left Hip</i>		20A. AUTOPSY? (Yes or No) <i>No.</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>AT HOME</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>1-18-68 8pm</i>					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>FELL ON HER LEFT HIP</i>				
22. I certify that (I) (this hospital) attended the deceased from <i>1-18-68</i> to <i>1-21-68</i> , that (I) (we) lost saw the deceased alive on <i>1-21-68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>TERUO KUWASHIMA</i>					23B. DATE SIGNED <i>1-21-68</i>						
23C. PHYSICIAN'S NAME (Type) <i>TERUO KUWASHIMA, M.D.</i>					23D. ADDRESS <i>40 SINAI HOSPITAL OF BALTIMORE BALTIMORE, MD. 21215</i>						
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>1/24/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Meadowridge Memorial Park</i>			24D. LOCATION (City, town, or county) (State) <i>Howard Co. Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 25 1968</i>			25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>			25C. FUNERAL DIRECTOR <i>McCully F.H.</i>			ADDRESS <i>237 Patapsco Ave. 21225</i>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>N-553</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>68 1027</u>	
1. NAME OF DECEASED (Type or Print) <u>NUNENTHAL, CHARLES</u>				2. DATE AND HOUR OF DEATH <u>1/22/68</u> <u>1:30 A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Sinai Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>27-18</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4924 Denmore Avenue</u>			
5. SEX <u>Male</u>	6. RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 28 1901</u>	9. AGE (In years lost birthday) <u>66</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Vendor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Food Vendor</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Aaron Nunenthal</u>				14. MOTHER'S MAIDEN NAME <u>Eva Kaufman</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Mrs Sylvia Rauner Rt 1 Bx 60AA</u>		ADDRESS <u>Stevensville Md.</u>	
18. <u>410.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>C.V.A. (Coronary Vascular Accident)</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Myocardial Infarction</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <u>C.V.A. (Coronary Vascular Accident)</u> (B) DUE TO, OR AS A CONSEQUENCE OF <u>Myocardial Infarction</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12/24-1/22</u> <u>12/21-1/22</u>	
19A. DATE OF OPERATION <u>420.1 II</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ureteric Stent Insertion</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>_____</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>_____</u>			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u>_____</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>_____</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>1/22/68</u> 19 to <u>1/22/68</u> 19, that (I) (we) last saw the deceased alive on <u>1/22/68</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>1/22/68</u>		23C. PHYSICIAN'S NAME (Type) <u>BEPTINGER</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/24/68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>3310 Taylor Ave Balto 34 Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Faulkner</u>		25C. FUNERAL DIRECTOR <u>Foring Byers Randall</u>			



C-436

68

1028

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68 1028

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ALBERT

CALDER

2. DATE OF DEATH

Known ☒ Estimated ☐

Month

Day

Year

Hour

January 20, 1968

1:00 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

University Hospital

3. DATE PRONOUNCED DEAD

Month

Day

Year

Hour

January 20, 1968

1:00 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

6/8/08

10. AGE (In years lost birthday)

59

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

3413 DuPont Circle

11. BIRTHPLACE (State or foreign country)

Belair, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

George C. Calder

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Cora B. Farrell

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

None

18. INFORMANT

Rosewood Records

ADDRESS

19.

E8871X

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

Subdural Hematoma

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Hospital

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

Rosewood State Hospital

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)

1/19/68 8:50 P.

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subj. fell

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/21/68

24A. BURIAL CREMATION, REMOVAL, (Specify)

Burial

24B. DATE

1/23/68

24C. NAME OF CEMETERY or CREMATORY

Rosewood Cemetery

24D. LOCATION (City, town, or county)

Owings Mills, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 25 1968

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

J. F. Eline & Sons

ADDRESS

Reisterstown, Md

THE UNIVERSITY OF CHICAGO

LIBRARY

500 EAST 57TH STREET

CHICAGO, ILLINOIS 60637

TEL: 773-936-5000

FAX: 773-936-5001

WWW.CHICAGO.EDU

CHICAGO, ILLINOIS 60637

CHICAGO, ILLINOIS 60637

CHICAGO, ILLINOIS 60637

CHICAGO, ILLINOIS 60637

CHICAGO, ILLINOIS 60637

CHICAGO, ILLINOIS 60637

CHICAGO, ILLINOIS 60637

CHICAGO, ILLINOIS 60637

CHICAGO, ILLINOIS 60637

CHICAGO, ILLINOIS 60637

CHICAGO, ILLINOIS 60637

CHICAGO, ILLINOIS 60637

CHICAGO, ILLINOIS 60637

CHICAGO, ILLINOIS 60637

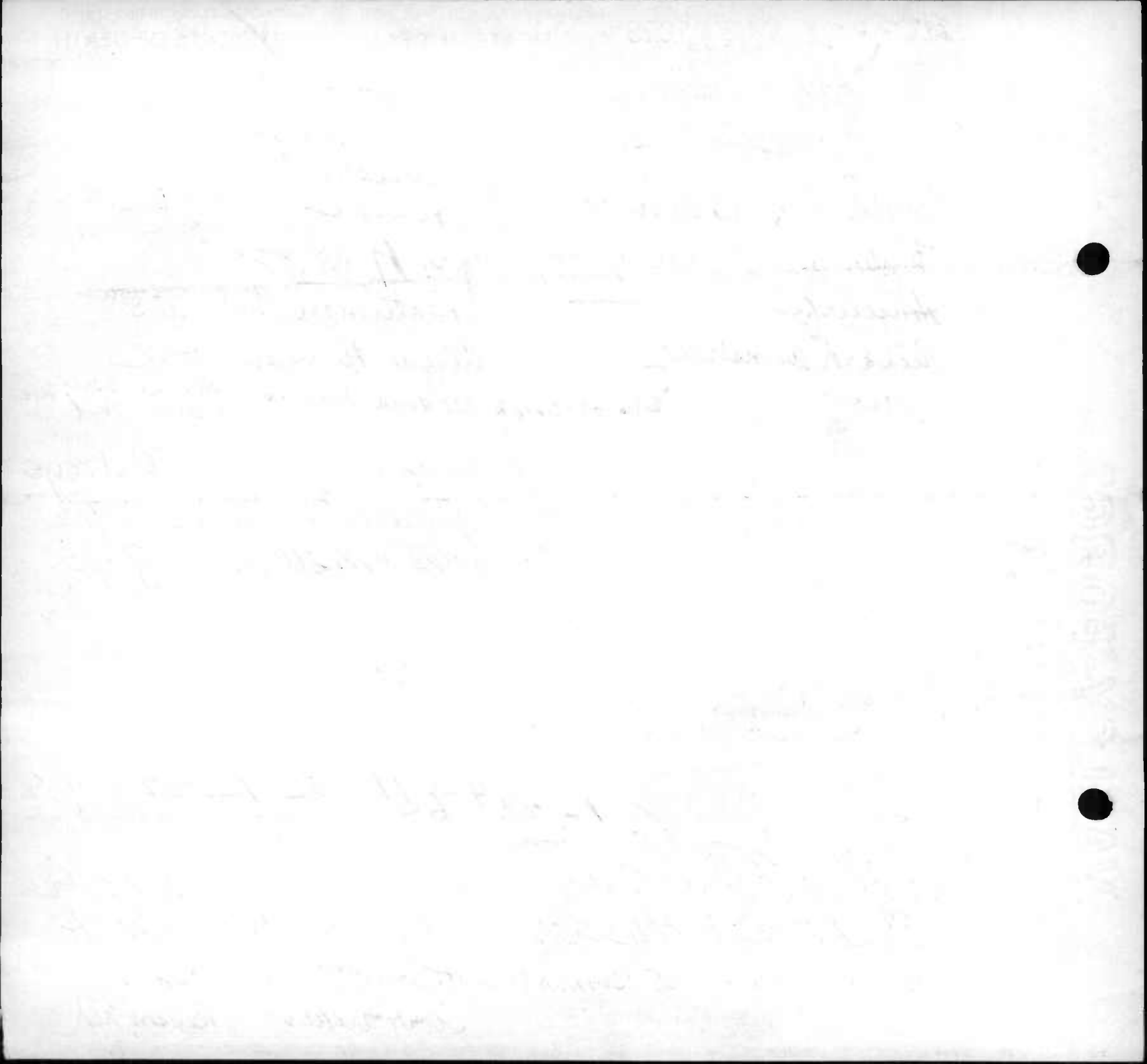
CHICAGO, ILLINOIS 60637

CHICAGO, ILLINOIS 60637

FUNERAL DIRECTOR: IMPORTANT

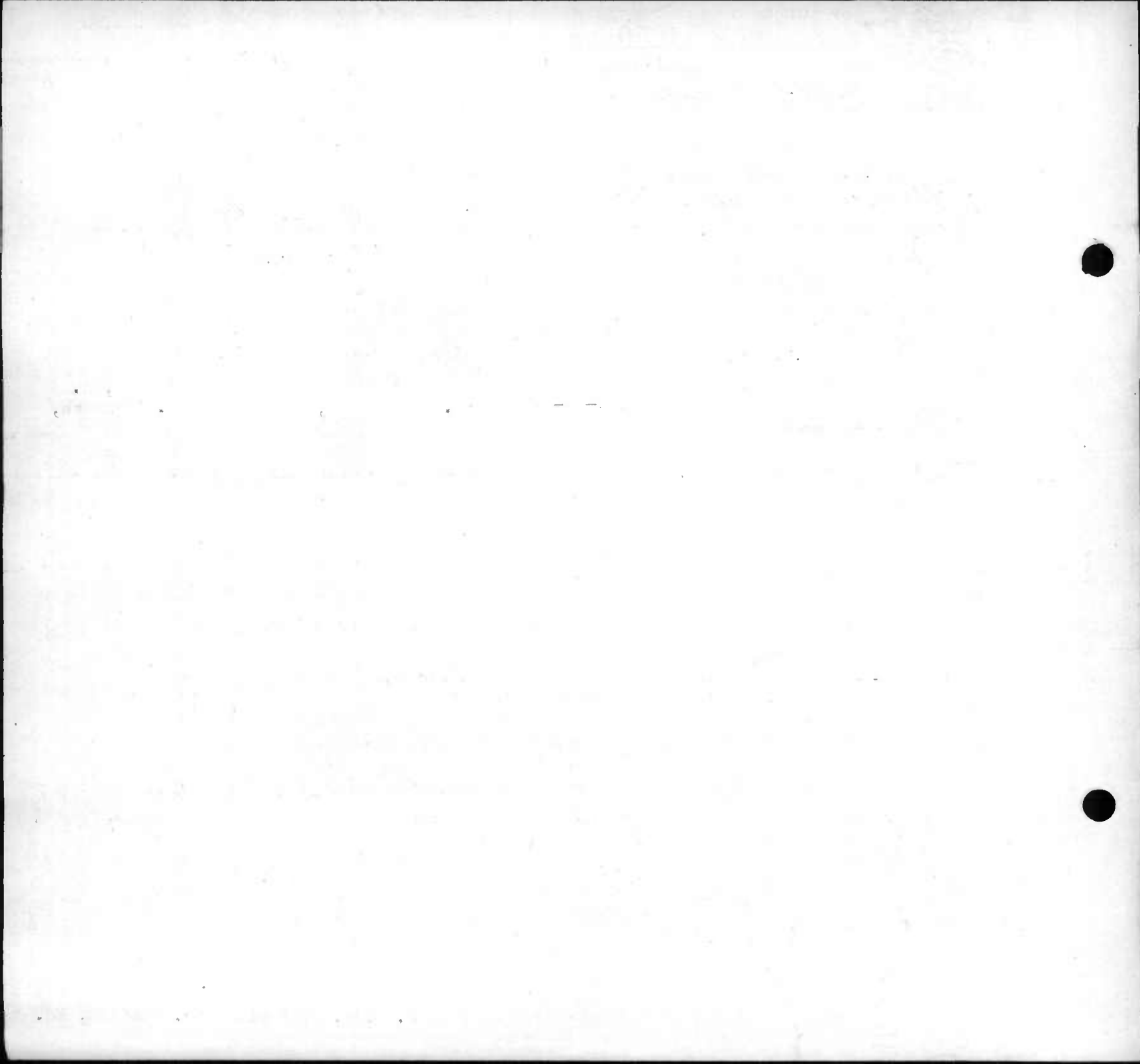
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-536 68 1029				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68 1029	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Jane Armstrong Anderson</i>				2. DATE AND HOUR OF DEATH <i>Jan 24 1968 6 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Goulds Convalesorium</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>md</i>		B. COUNTY <i>Harford</i>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Fallston</i>			
				D. STREET ADDRESS (If rural, give location) <i>Rural 62-00</i>			
5. SEX <i>Female</i>	6. RACE <i>w</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>apr. 19 1885</i>	9. AGE (In years last birthday) <i>82</i>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Richard Armstrong</i>				14. MOTHER'S MAIDEN NAME <i>Eliza Hannah Hill</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>				16. SOCIAL SECURITY NO. <i>216-07-2296</i>		17. INFORMANT <i>Mrs Anna Mangel</i>	
18. <i>470 X I 250.9</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Influenza</i> DUE TO (B) <i>hypertensive cardiovascular dis</i> DUE TO (C) <i>Diabetes mellitus</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i> <i>16 yrs.</i> <i>9 yrs.</i>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>481X II</i>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>9-21-68</i> to <i>1-22-68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Clifford F. Hudson</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>1/23/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>CLIFFORD F. HUDSON</i>				23D. ADDRESS <i>FORK MD, Balto.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Jan 25, 1968</i>		24C. NAME OF CEMETERY or CREMATORY <i>Govans Presbyterian</i>		24D. LOCATION (City, town, or county) (State) <i>FORK RD Balto - Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 25 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairbanks</i>		25C. FUNERAL DIRECTOR <i>W. H. Archer</i>		ADDRESS <i>Benson, Md</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						68 1030	
5-260 68 1030						REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ANNA SHKOR		2. DATE AND HOUR OF DEATH 21 JAN 68		8:40 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hospital MARYLAND GENERAL HOSP				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Baltimore C. CITY OR Edgemere D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 3224 GRACE RD. 53-0			
5. SEX Female	6. RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 DEC 93	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Egnoth Strygelski				14. MOTHER'S MAIDEN NAME MARY KAY OWCZYNSKI			
15. Was Deceased ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-67-4426		17. INFORMANT (Son) ADDRESS Md. Mr. Alex Shkor, 3224 Grace Rd. Edgemere,			
18. 18219 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE METASTATIC CA UTERUS DUE TO, OR AS A CONSEQUENCE OF: 3 YRS (B) DUE TO, OR AS A CONSEQUENCE OF: (C) CONGESTIVE HEART FAILURE				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
174X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 174X II							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) REFUSED		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 18 JAN 19 68 to 21 JAN 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 21 JAN 19 68 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. J. Oldroyd M.D.				23B. DATE SIGNED 1/31/68		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) J. J. Oldroyd M.D.				23D. ADDRESS MARYLAND GENERAL HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/26/68		24C. NAME OF CEMETERY or CREMATORY Holy Trinity Cemetery		24D. LOCATION (City, town, or county) (State) Elkridge, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1968		25B. NAME OF REGISTRAR Robert E. Tuley		25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md.			



CERTIFICATE OF DEATH

REG. NO.

68

1031

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Virgie M. McCune

2. DATE AND HOUR OF DEATH

1/21/68

6: 50 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Ave.

Baltimore, Maryland # 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN

Edgemere

D. INSIDE CITY LIMITS?

YES ☒NO ☒

E. STREET AND NUMBER

421 Willow Ave. 21219

5. SEX

Female

6. RACE

White

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

5-14-02

9. AGE (In years last birthday)

65

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Dock McCune

14. MOTHER'S MAIDEN NAME

Virginia Short

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

232-32-2410

17. INFORMANT

4940 Eastern Ave.

ADDRESS

BCH: Records Baltimore, Maryland #21224

18. 410.9 I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cardiac arrest

20-30 mins

(B) ? myocardial infarct

DUE TO, OR AS A CONSEQUENCE OF:

2 1/2 days

(C)

420.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from

that (I) (we) last saw the deceased alive on Jan 21 1968

Jan 20 1968 to 6:50 PM Jan 21 1968

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

F. Y. Aoki MD

Attending Phys. ☒Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

Jan 21/68

23C. PHYSICIAN'S NAME (Type)

F. Y. Aoki MD

23D. ADDRESS

4940 Eastern Ave. Baltimore, Md. City of Balto. City #21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1/24/68

24C. NAME of CEMETERY or CREMATORY

Gardens of Faith Cemetery

24D. LOCATION

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JAN 25 1968

25B. NAME OF REGISTRAR

Robert E. Fulkerson

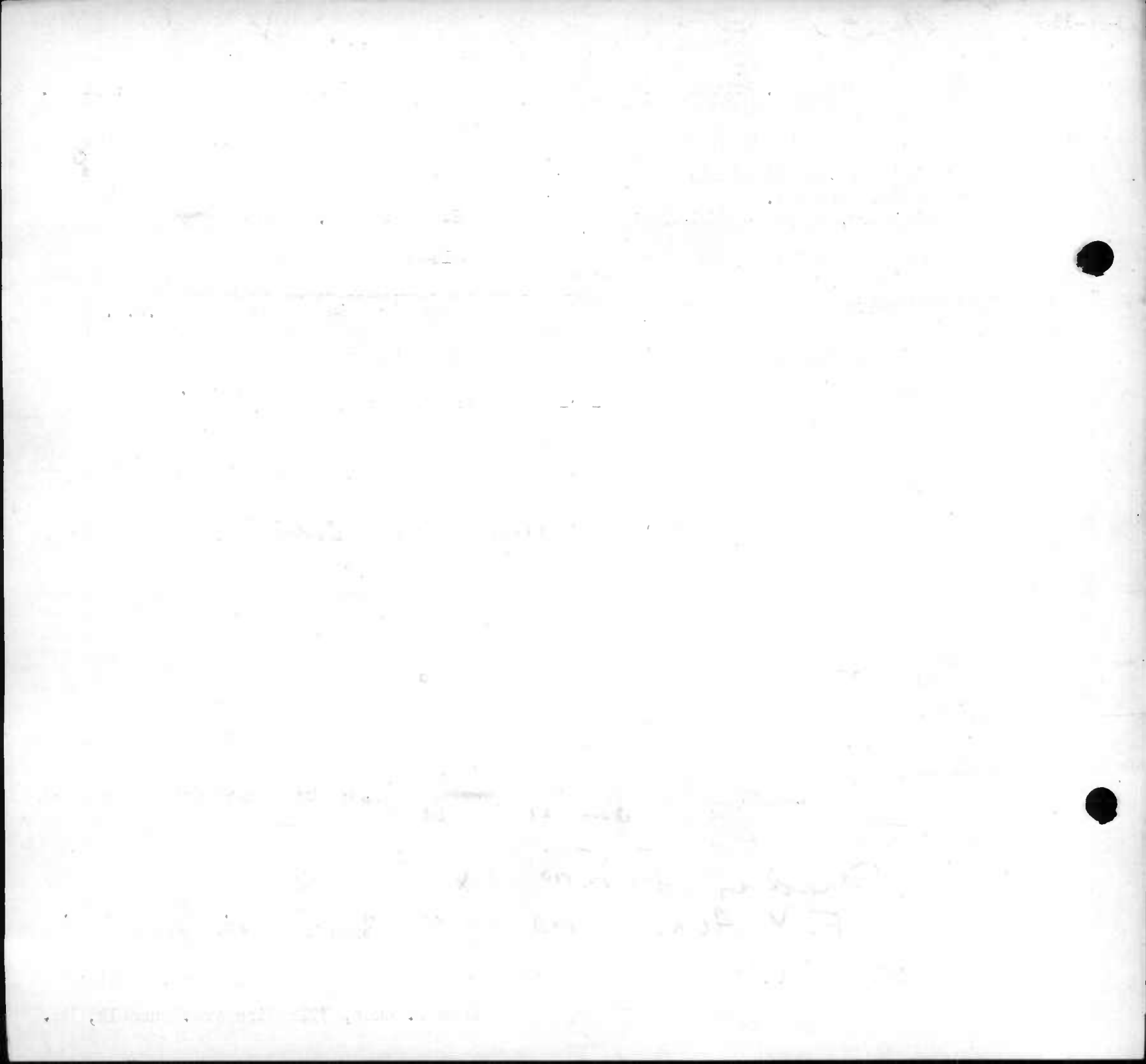
25C. FUNERAL DIRECTOR

John J. Duda, 7922 Wise Ave. Dundalk, Md.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



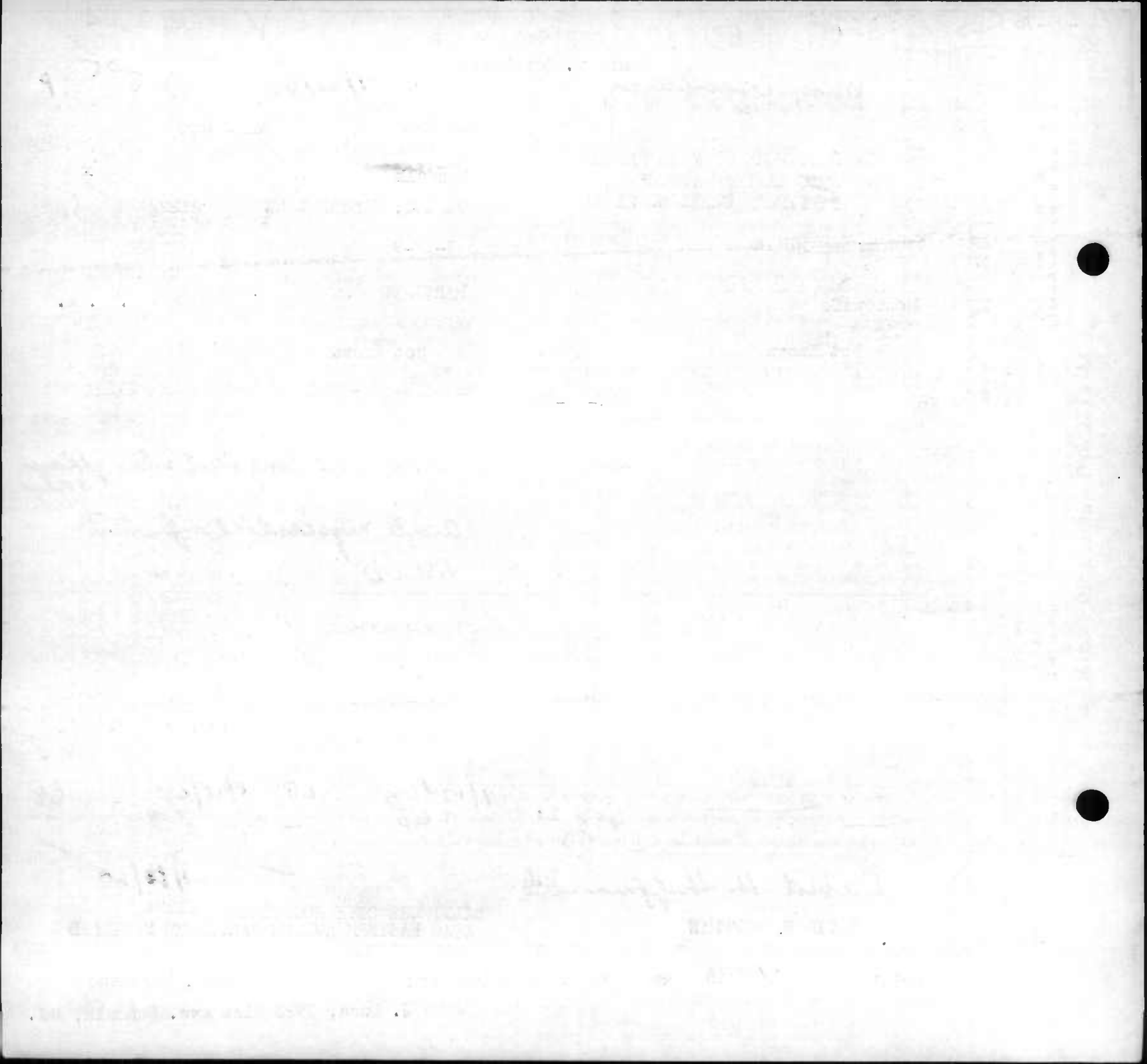
43-03-76

ME

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68 1032	
B-626 68 1032 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Mary M. Brashears</i>		2. DATE AND HOUR OF DEATH <i>1/21/68 8:05 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE MARYLAND 21224</i>			C. CITY OR TOWN <i>Dundalk</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <i>FEMALE</i> 6. RACE <i>WHITE</i>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3-18-95</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years lost birthday) <i>72</i>
11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>			12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		
13. FATHER'S NAME <i>Not Known</i>			14. MOTHER'S MAIDEN NAME <i>Not Known</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>214-12-8456</i>		17. INFORMANT ADDRESS <i>RECORDS-BCH-4940 EASTERN AVENUE 21224</i>
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Shock and Cong Heart Failure 1 day + 3 days</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF: <i>ASCVD</i> (C) <i>Pneumonia 1</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>420.1 II</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11/17/68</i> 19 <i>68</i> to <i>1/21/68</i> 19 <i>68</i> , that (I) <i>(we)</i> lost saw the deceased alive on <i>Jan 21</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>David H. Huffman</i>				23B. DATE SIGNED <i>1/25/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>DAVID H. HUFFMAN</i>				23D. ADDRESS <i>BALTIMORE CITY HOSPITALS 21224 4940 EASTERN AVENUE BALTIMORE MARYLAND</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/25/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Meadowridge Memorial Park</i>	
24D. LOCATION <i>Dorsey, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 25 1968</i>			
25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR ADDRESS <i>John J. Duda, 7922 Wise Ave. Dundalk, Md.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68 1033</u>
H-530		68 1033		CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>NORMA E. HUNT</u>		
2. DATE AND HOUR OF DEATH <u>1-17-68</u> <u>4.00 A</u> M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 THE JOHNS HOPKINS HOSPITAL</u>		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE CITY</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <u>FEMALE</u> 6. RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <u>2036 BANK ST</u> <u>21231</u>		
8. DATE OF BIRTH <u>2-22-12</u> 9. AGE (In years last birthday) <u>55</u>		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		
10B. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>HARRY KARN</u>		
14. MOTHER'S MAIDEN NAME <u>EDNA MAE KNADLER</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>215-18-1355</u>		17. INFORMANT <u>Edward Norris, Millers, Md.</u> ADDRESS <u>Route 1</u>		
18. <u>486X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Acute pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (B) <u>Chronic lung disease of ? etiology</u> DUE TO, OR AS A CONSEQUENCE OF (C) <u>CHF</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>		
19. DATE OF OPERATION <u>2</u>		20. AUTOPSY? (Yes or No) <u>Yes</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>1/17 at 4AM</u> <u>1968</u> to <u>1/17</u> <u>1968</u> , that (I) (we) last saw the deceased alive on <u>1/17 at 4AM</u> <u>1968</u> and that (I) (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <u>Allen B. Kaiser MD</u> 23B. DATE SIGNED <u>1/17/68</u>		
23C. PHYSICIAN'S NAME (Type) <u>Allen B. Kaiser MD</u>		23D. ADDRESS <u>I/HH</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/20/68</u>		
24C. NAME OF CEMETERY OR CREMATORY <u>Locust Valley Ch. of God Middletown, Fred., Md.</u>		24D. LOCATION (City, town, or county) (State)		
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1968</u>		25B. NAME OF REGISTRAR <u>E. Taylor</u>		
25C. FUNERAL DIRECTOR <u>Gladhill Company, Middletown, Md.</u>		ADDRESS		

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

FUNERAL DIRECTOR: IMPORTANT

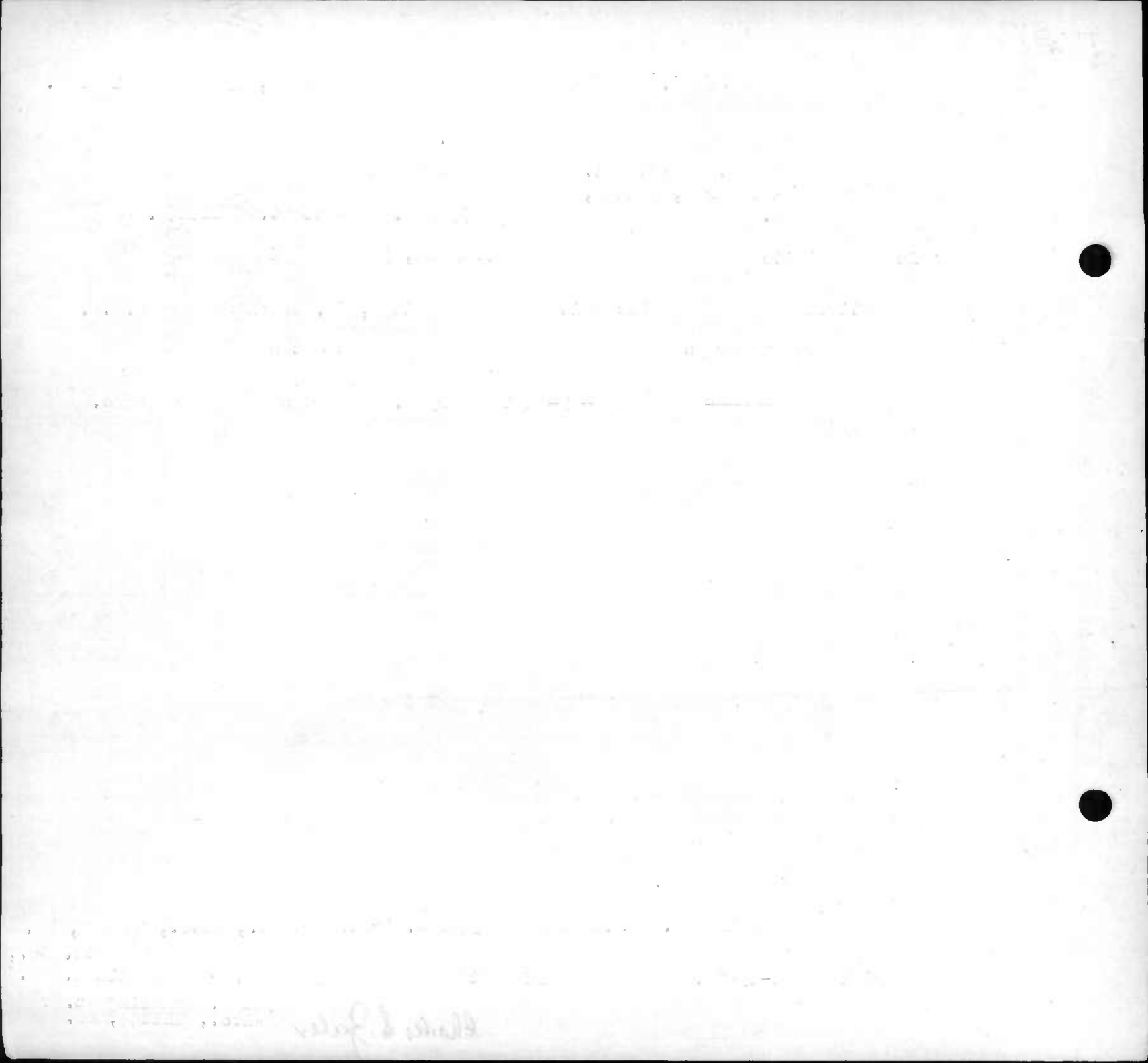
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

68 1034 CERTIFICATE OF DEATH

REG. NO. 68 1034

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ROY F. HUMPHREYS		January 22, 1968 2:00 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 00				A. STATE Md. 26-44	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3500 E. Fayette St. Baltimore, 21224, Md.				B. CITY OR TOWN Baltimore	
				C. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3500 E. Fayette St. # 21224.	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	July 12, 1906	61	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired		Mechanic		Easley, So. Carolina	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Zeb Humphreys			Mae Oates		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		249-09-1151		Mary C. Humphreys	
				ADDRESS	
				Same.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
1621 I					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1967 to 1/22 1968, that (I) (we) lost saw the deceased alive on 1/7 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Julius H. Goodman				1/25/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
				3400 E. Baltimore St., Balto., 21224, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1-25-68.		Gardens of Faith	
				24D. LOCATION (City, town, or county)	
				Kenwood Ave. & Trumps Mill Rd. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 26 1968		Charles E. Fairbank		Charles S. Gailer	
				ADDRESS	
				901 S. Conkling St. Balto., 21224, Md.	



C-436

68 1035 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68 1035

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) ROY K. CHILDRESS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 1 21 68 12:20 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 60 527 Oldham St.		3. DATE PRONOUNCED DEAD Month Day Year Hour January 21 1968 12:20 p.m.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 26-07	
9. DATE OF BIRTH Aug. 5, 1909		10. AGE (In years lost birthday) 58 (58)	
11. BIRTHPLACE (State or foreign country) Portsmouth, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? Childress		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed	
15. MOTHER'S MAIDEN NAME Elizabeth ?		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war and date of service) Yes W.W.II	
17. SOCIAL SECURITY NO. 229-07-8627		18. INFORMANT 1311 Bunsen Way Margaret M. Childress Balto., 24, Md.	
19. 412.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Intracerebral hemorrhage (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive Arteriosclerotic Cardiovascular Disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED January 22, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-24-68	
24C. NAME OF CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Balto., 24, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1968		25B. NAME OF REGISTRAR Robert E. Taylor, MA	
25C. FUNERAL DIRECTOR Charles A. Geiler		ADDRESS 9015 CONKLING ST. BALTO., 21224, MD.	

6012 CORNING ST
BURLINGTON, VT

WALLACE BROWN

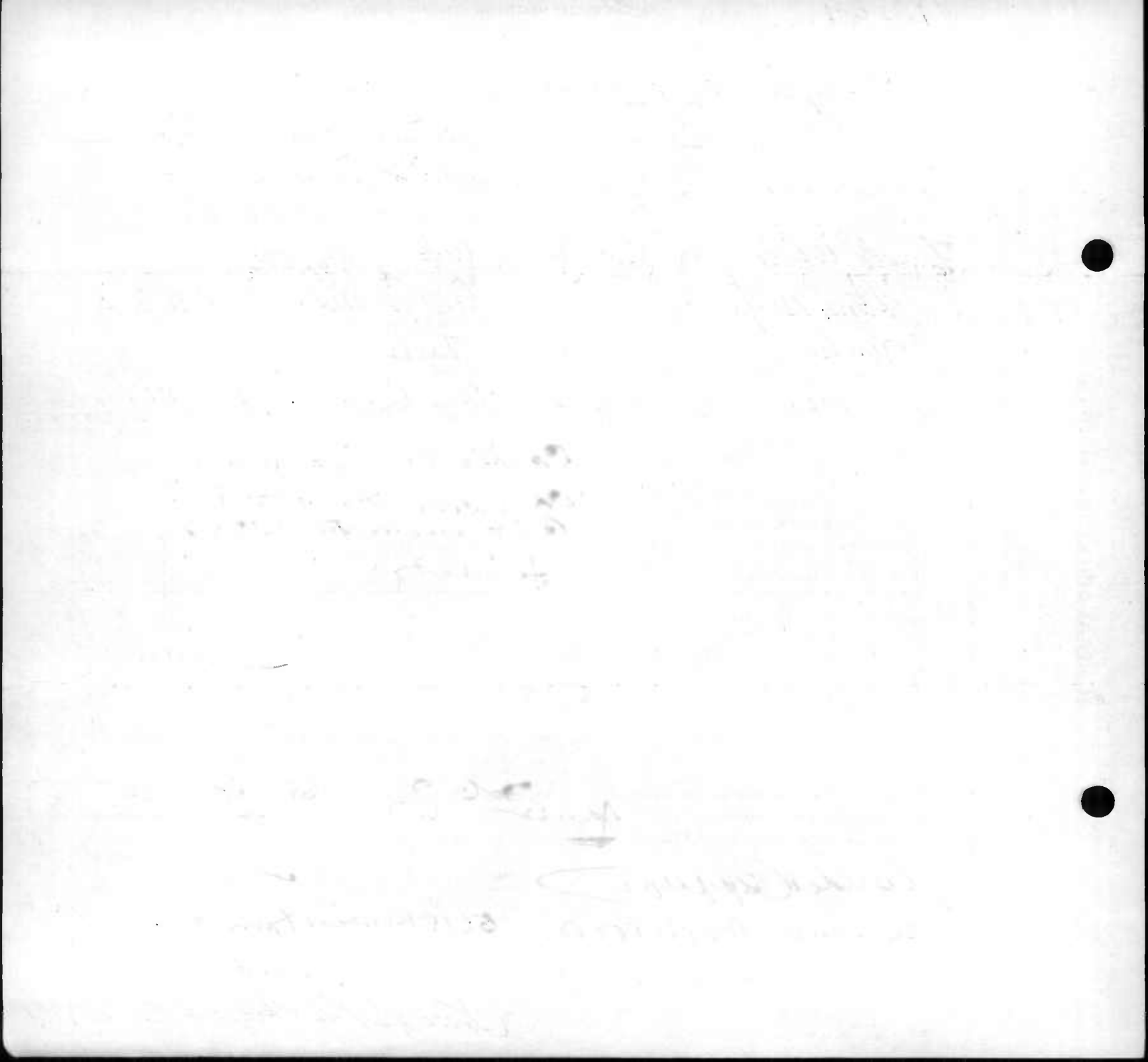
25% PAID

PAID

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

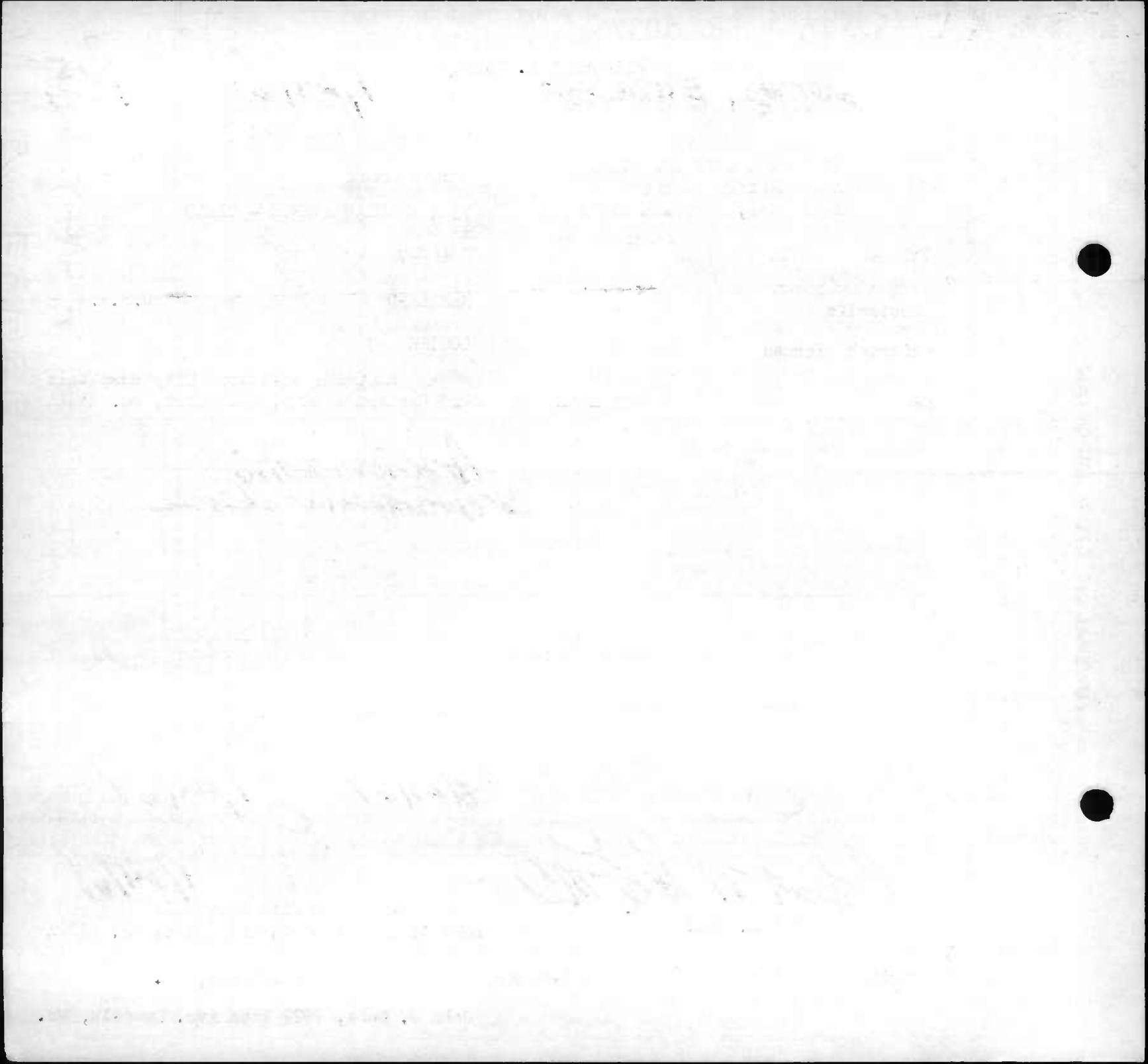
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO.	
M254 68 1036						68 1036	
1. NAME OF DECEASED (Type or Print) <i>Maggie Mc Mullen</i>				2. DATE AND HOUR OF DEATH <i>1/22/68</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>102 W. PACA ST</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Baltimore, Md.</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>102 W. PACA ST</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 82</i>	9. AGE (In years last birthday) <i>82</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>unk</i>				14. MOTHER'S MAIDEN NAME <i>unk</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No.</i>		16. SOCIAL SECURITY NO. <i>unk</i>		17. INFORMANT <i>Hosp Records Baltimore Md</i>		ADDRESS	
18. <i>4/29/1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Cardio-Respiratory Failure</i> <i>Arteriosclerotic Heart Disease</i> <i>Arteriosclerotic CVD</i> <i>Senility</i>				CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. DATE OF OPERATION <i>22.1</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>II</i>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		20A. AUTOPSY? (Yes or No)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
22. I certify that (I) (this hospital) attended the deceased from <i>Feb 9</i> 19 <i>65</i> to <i>Jan 22</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>Jan 22</i> 19 <i>67</i> and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above. (I) (We) <i>(did)</i> (did not) view the body after death.							
23A. SIGNATURE <i>William D Appleford</i>				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <i>William D Appleford</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <i>1/24/68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Angel Hill</i>		24D. LOCATION (City, town, or county) (State) <i>Harold Chase Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 26 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Joseph R. Harold Chase Md</i>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68	1037
D-620		68 1037		CERTIFICATE OF DEATH		
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Dorsey, Elizabeth		2. DATE AND HOUR OF DEATH 1/24/68 1:45 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE				
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224		C. CITY OR TOWN Jones Creek		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/10/97
9. AGE (In years lost birthday) 70		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Heinrich Eierman		14. MOTHER'S MAIDEN NAME LOUISE ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 213-07-8536 B		17. INFORMANT RECORDS: Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224				
18. 437.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cerebrovascular disease		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 334X II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 8/29/67 19 to 1/24/68 19, that (I) (we) last saw the deceased alive on _____ 19 and that in (my) (our) opinion death occurred on the date _____ and hour _____ and from the causes stated above (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Robert N. Hill MD		23B. DATE SIGNED 1/24/68		
23C. PHYSICIAN'S NAME (Type) ROBERT N. HILL		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/27/68		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE RECEIVED BY HEALTH DEPT. JAN 25 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68 1038

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68 1038

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

JEDRZEJEWSKI, ANNA R.

2. DATE AND HOUR OF DEATH

JANUARY 21, 1968

12:30P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

ST. AGNES HOSPITAL
WILKENS & CATON AVES.
BALTIMORE, MD. 21229

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

21225

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

3514 - 4TH STREET

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED ☐

NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

07-04-87

9. AGE (In years)

80

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

HOUSEWIFE

11. BIRTHPLACE (State or foreign country)

POLAND

12. CITIZEN OF WHAT COUNTRY?

POLAND

13. FATHER'S NAME

Peter -----

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

NO

16. SOCIAL SECURITY NO.

218-05-9043

17. INFORMANT

WILKENS & CATON AVES.
ST. AGNES RECORDS-BALTIMORE, MD. 21229

18. 250.91

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Pneumonia, Hypertension
Diabetes Mellitus.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from DECEMBER 29, 19 67 to JANUARY 21, 19 68, that (X) (we) last saw the deceased alive on JANUARY 21, 19 68 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.

23A. SIGNATURE

M. Alvarez M.D.

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type)

MARIA ALVAREZ M. D.

DEGREE

23D. ADDRESS

WILKENS & CATON AVES.
ST. AGNES HOSPITAL-BALTIMORE, MD. 21229

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1-25-1968

24C. NAME OF CEMETERY or CREMATORY

Holy Rosary Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JAN 26 1968

George J. Gonce

George J. Gonce-4001 Ritchie Hwy., Baltimore

9036

56

5-11-01

T-460
W-452

68 1039

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68 1039

BIRTH NO.

1. NAME OF DECEASED (Type or Print) DOROTHY TAYLOR (Williams)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> January 24, 1968		Hour 11:55 P.M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital		3. DATE PRONOUNCED DEAD Month Day Year January 24, 1968		Hour 11:55 P.M.
6. SEX Female		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH Nov. 16, 1938		10. AGE (In years last birthday) 29		11. BIRTHPLACE (State or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Murphy		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress
15. MOTHER'S MAIDEN NAME Lula Williams		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 213-32-7666
18. INFORMANT Lula Williams		ADDRESS same		

19. CAUSE OF DEATH Massive subarachnoid hemorrhage		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: and brain contusions		
(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) DUE TO, OR AS A CONSEQUENCE OF:		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). None		

20A. DATE OF OPERATION 2	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21. AUTOPSY? (Yes or No) Yes
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Unknown	22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Unknown
22D. TIME OF INJURY (APPROX.) Unknown	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> Unknown	22F. HOW DID INJURY OCCUR? Presumably fell

23. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: **Natural causes** ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: **Charles S. Springate** M.D.
EXAMINER'S NAME (Type): **Charles S. Springate, M.D.**

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED: **January 25, 1968**

24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 1-30-1968	24C. NAME OF CEMETERY or CREMATORY MO. Auburn Cem.	24D. LOCATION (City, town, or county) (State) Baltimore Md.
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1968	25B. NAME OF REGISTRAR Robert E. Farber	25C. FUNERAL DIRECTOR Chas. O. Wilson	ADDRESS 1000 Brantley Ave.

Letter from M.E.'s office

3-4-68 M.H.

VALLEY PAPER
VALLEY FOR
VALLEY PAPER

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68 1040

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

BLACK MARY

2. DATE AND HOUR OF DEATH

1/21/68 1⁰⁰am M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)Balt. City Hospitals
4940 Eastern Ave.
Baltimore, Maryland # 212244. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1821 Edmondson Ave. #21223

5. SEX

Female

6. RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

4-15-1898

9. AGE (In years
lost birthday)

69

If Under 1 Yr.

Months: Days: Hours: Min.

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Edward

Black

14. MOTHER'S MAIDEN NAME

Ann

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

4940 Eastern Ave.

ADDRESS

BCH: Records Baltimore, Maryland #21224

18. 436.9 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

331X II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/10/1968 to 1/21/1968,
that (I) (we) last saw the deceased alive on 1/20/1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

A. Koksashian

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

1/21/68

23C. PHYSICIAN'S
NAME (Type)

A. Koksashian

23D. ADDRESS

4940 Eastern Ave. Baltimore, Maryland

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1-25-68

24C. NAME OF CEMETERY or CREMATORY

Mt. Calvary C.

24D. LOCATION

Brooklyn

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 28 1968

25B. NAME OF REGISTRAR

A. B. E. Johnson

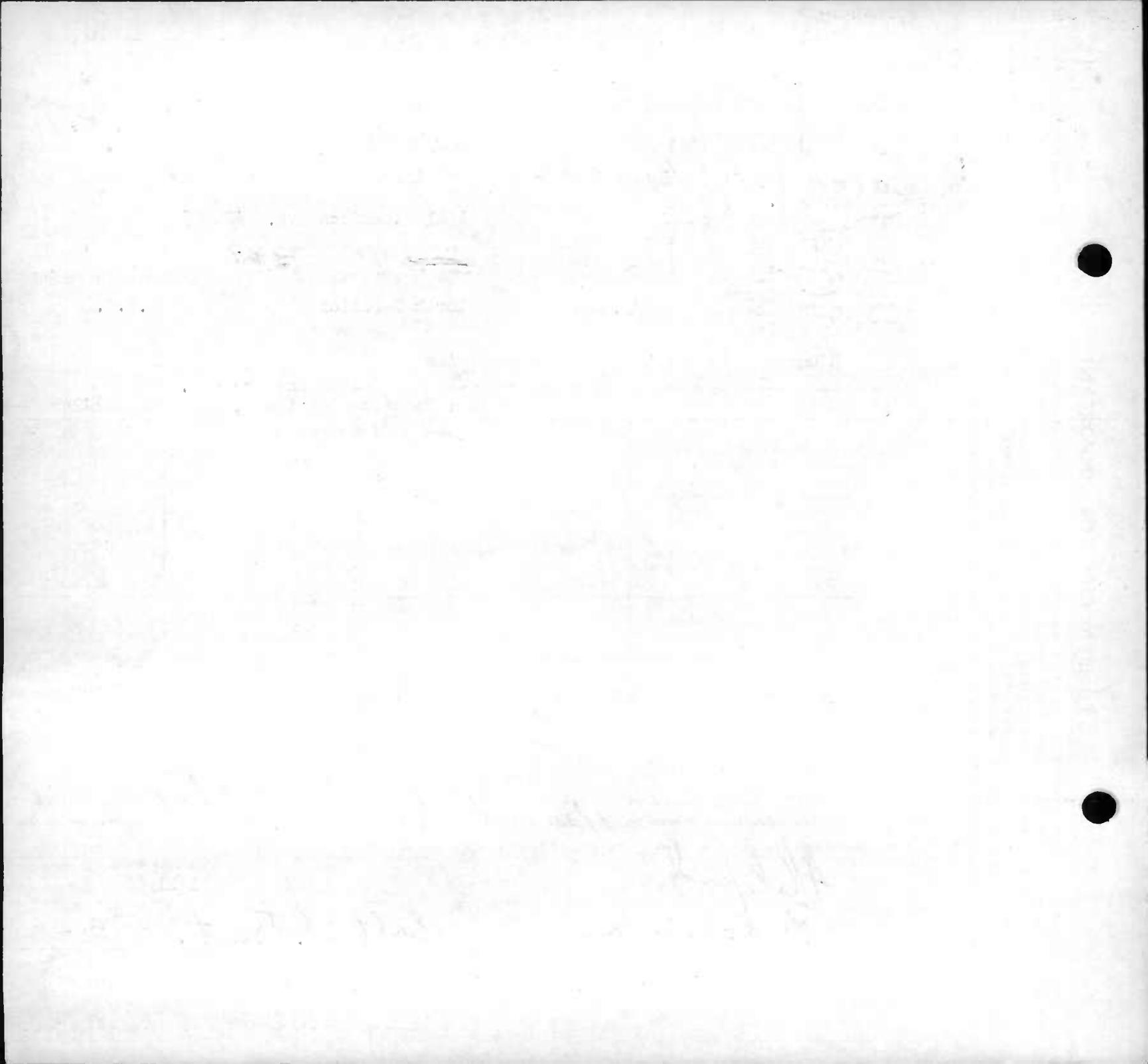
25C. FUNERAL DIRECTOR

Chung & Wilson 1000 Broadway Ave.

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68 1041

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHNNIE HARRIS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> January 23, 1968 9:45 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Church Home Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour January 23, 1968 9:45 A.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-01		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX male	7. RACE negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH	10. AGE (In years lost birthday) 52	E. STREET AND NUMBER 1400 E. Baltimore Street	
11. BIRTHPLACE (State or foreign country) P.O. North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Ludie Harris	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES		17. SOCIAL SECURITY NO. 240-18	
19. 345.9		18. INFORMANT ADDRESS Joe Louis Harris 1909 Memorial Ave	
19. 345.9		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		Death During Epileptic Seizure (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1/23/68	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 1-29-68	24C. NAME of CEMETERY or CREMATORY B. Nat. Cent	24D. LOCATION (City, town, or county) (State) Balto Md
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1968	25B. NAME OF REGISTRAR Robert E. Jackson	25C. FUNERAL DIRECTOR ADDRESS Elroy W. Wilson 1200 Broadway St	

WALLINGFORD CO. 1868

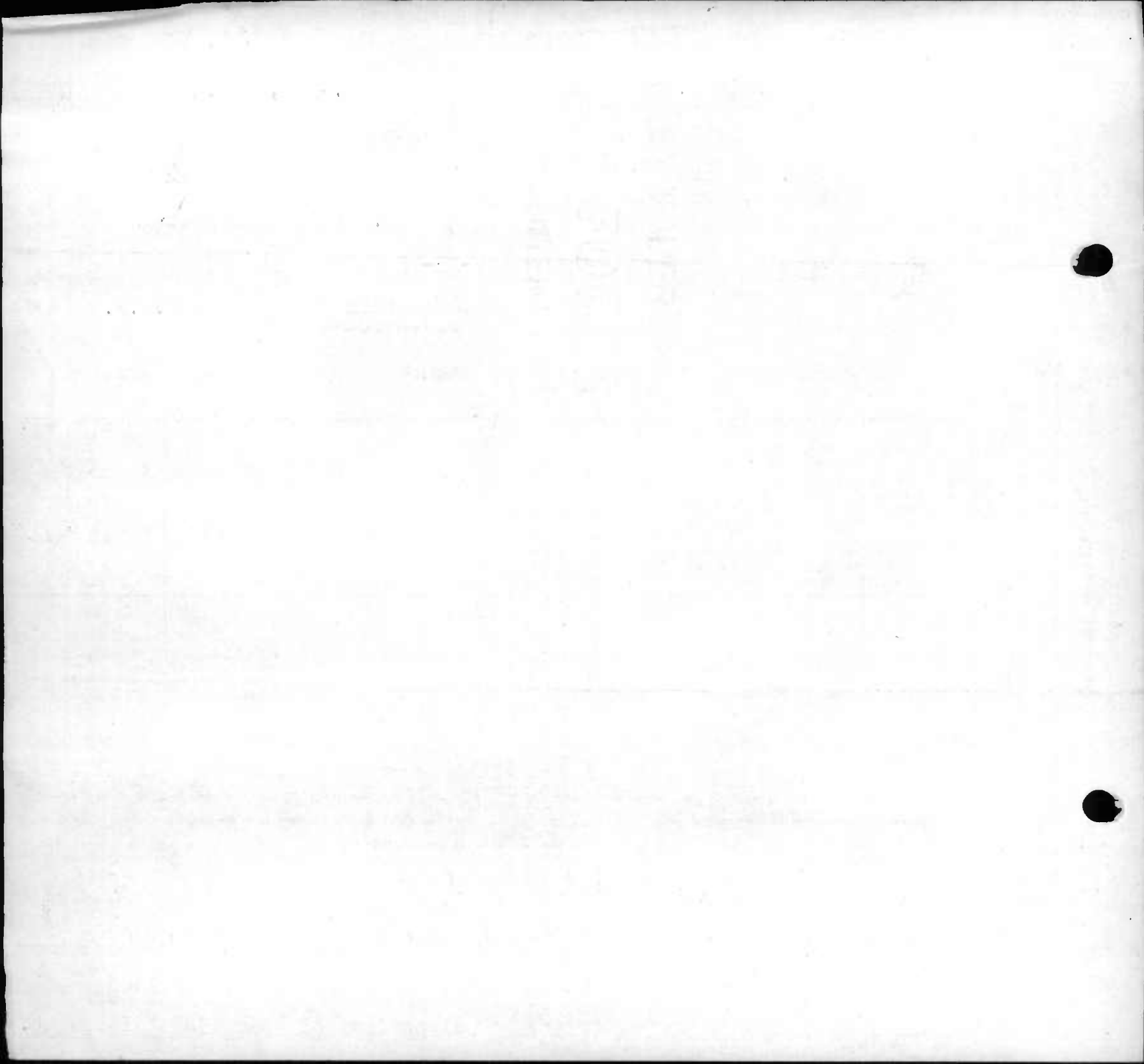
25-10-1868

Wm. Wallingford

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68 1042
68 1042		BIRTH NO.		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
Nannie E. Buchanan		Jan. 23, 1968 6:15 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1112 N. Stricker Street Baltimore, Maryland 21217		A. STATE Maryland		
		B. COUNTY		
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER		
		1112 N. Stricker Street		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
Female	Negroid	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7-23-73	94
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
				Virginia
12. CITIZEN OF WHAT COUNTRY?		U.S.A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT
no				Alice Diggs 3704 Duval Avenue
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Cerebral accident one day		
		(B) Arterio sclerosis + myocardial over 4 years		
		(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from 12-18-1967 to 1-25-1968, that (I) (we) last saw the deceased alive on 1-25-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE				23B. DATE SIGNED
John E. J. Camper, M.D.				1-2-5-68
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
JOHN E. J. CAMPER, M.D.		1039 L. Carey St., Baltimore, Md		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	1-27-68	New Cathedral Cemetery	Baltimore,	Maryland
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		
1-27-68	Robert E. Jackson	Elson Funeral Home 1348 Calhoun St.		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/6B

UNITED STATES DEPARTMENT OF THE ARMY
OFFICE OF THE CHIEF OF STAFF
WASHINGTON, D. C. 20315

100-100000
100-100000

100-100000
100-100000

100-100000

100-100000

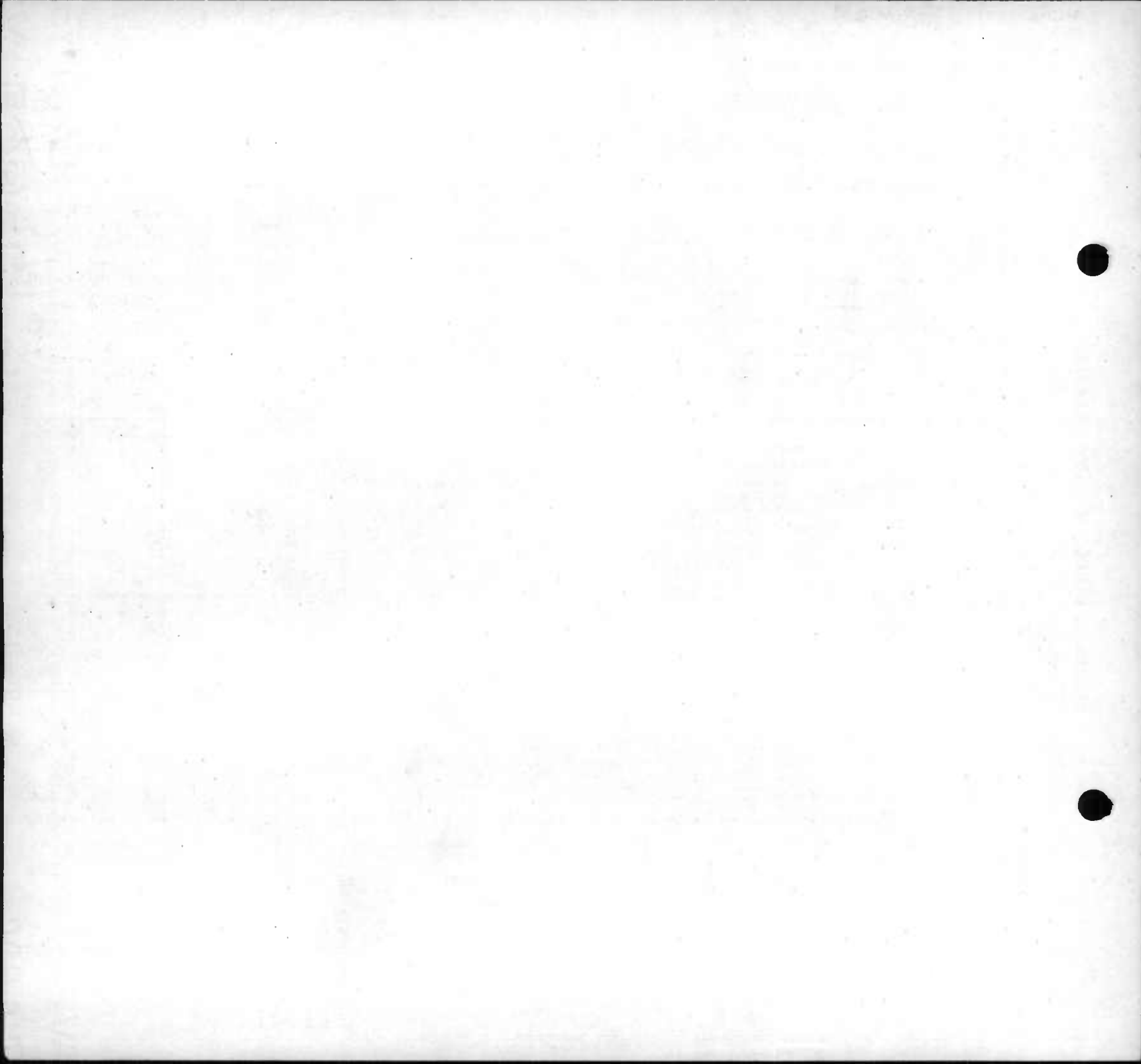
100-100000

100-100000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

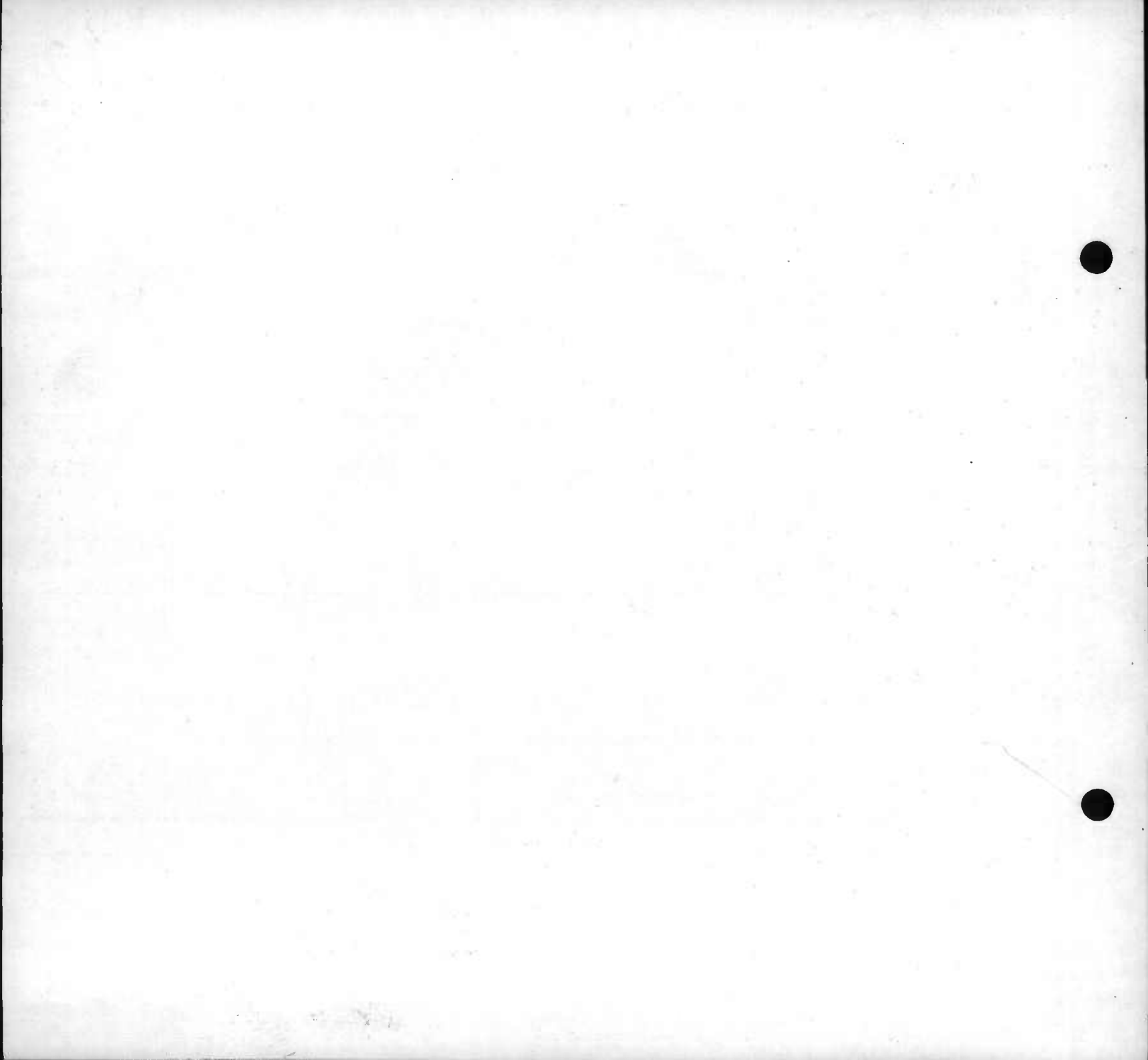
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68 1044
1. NAME OF DECEASED (Type or Print) Yolando JONES		2. DATE AND HOUR OF DEATH 1-18-68 5¹⁵ A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2529 Hollins Street		
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-13-67	9. AGE (In years last birthday) 1 5 — —
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME UNKNOWN		
14. MOTHER'S MAIDEN NAME MARLENE JONES "same"		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —		
16. SOCIAL SECURITY NO. —		17. INFORMANT GARY A. FLEMING, M.D. ADDRESS —		
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 15%; text-align: center;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MONTH </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 80%;"> (A) IMMEDIATE CAUSE D. Syndrome DUE TO, OR AS A CONSEQUENCE OF: </div> <div style="width: 15%; text-align: center;"> (B) DUE TO, OR AS A CONSEQUENCE OF: </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 80%;"> (C) DUE TO, OR AS A CONSEQUENCE OF: </div> <div style="width: 15%; text-align: center;"> (D) DUE TO, OR AS A CONSEQUENCE OF: </div> </div>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

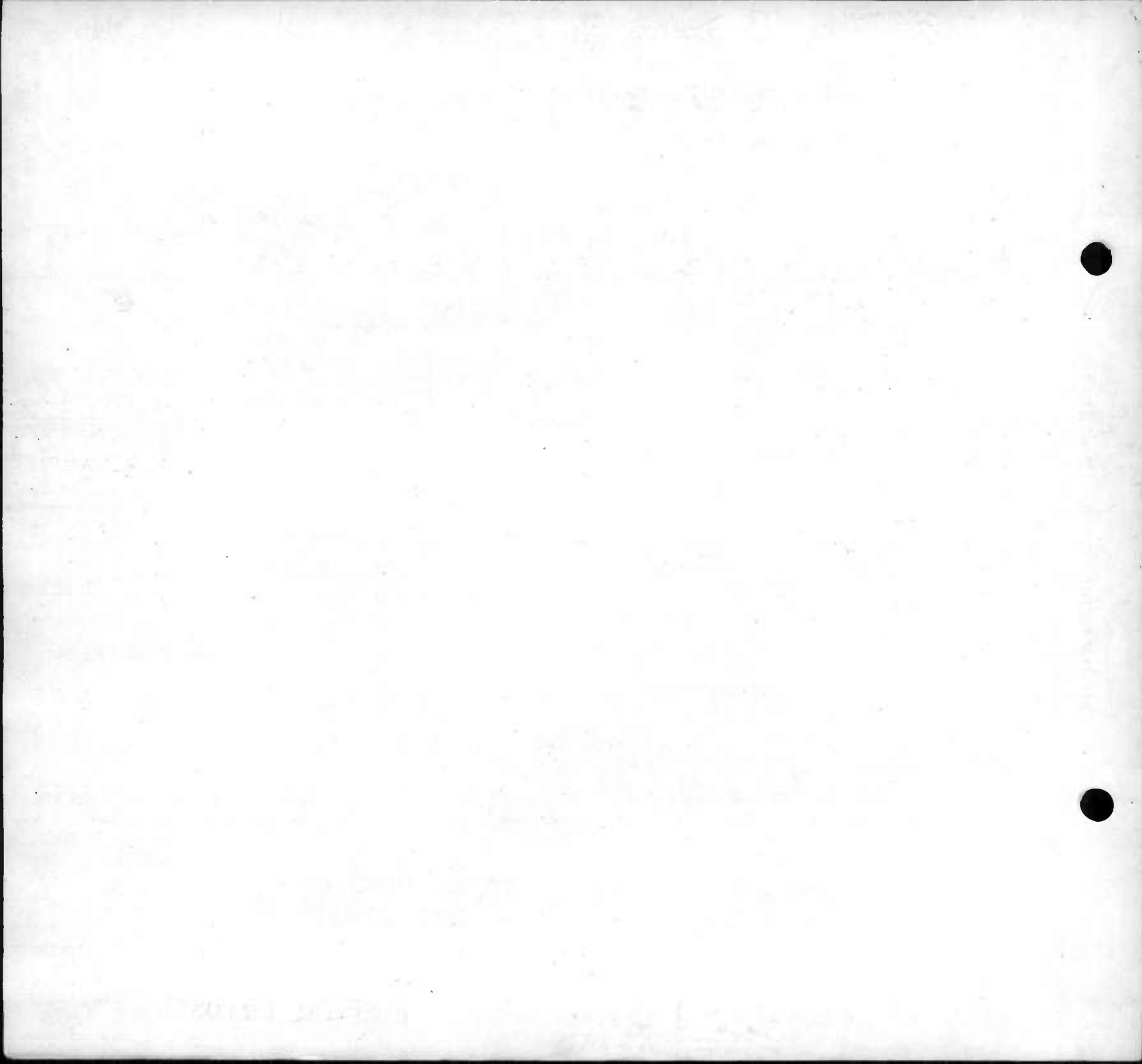
BALTIMORE CITY HEALTH DEPARTMENT						REG. NO. 68 1045
<div style="display: flex; justify-content: space-between;"> R-300 68 1045 </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div>						
1. NAME OF DECEASED (Type or Print) B. B. Redd-			2. DATE AND HOUR OF DEATH 1/20/68 4:30 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Univ. Hosp (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 14-02			
			C. CITY OR TOWN Balto		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
			E. STREET AND NUMBER 1610 Druid Hill Ave			
5. SEX m	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 12	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		
13. FATHER'S NAME Sherman Redd			14. MOTHER'S MAIDEN NAME Mildred Gibson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
18. 777X I CAUSE OF DEATH						
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Prematurity			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:			
			(C) DUE TO, OR AS A CONSEQUENCE OF:			
18. 776Y II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).						
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 1/20 19 68 to 1-20 19 68 , that (I) (we) last saw the deceased alive on 1-20 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE Adel Rounstein, M.D.				23B. DATE SIGNED 1/20/68		
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS ANATOMY BOARD OF MARYLAND		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1-22-68		24C. NAME OF CEMETERY or CREMATORY JOHNS HOPKINS MEDICAL SCHOOL		
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1968		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS HOSPITAL DISPOSAL		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

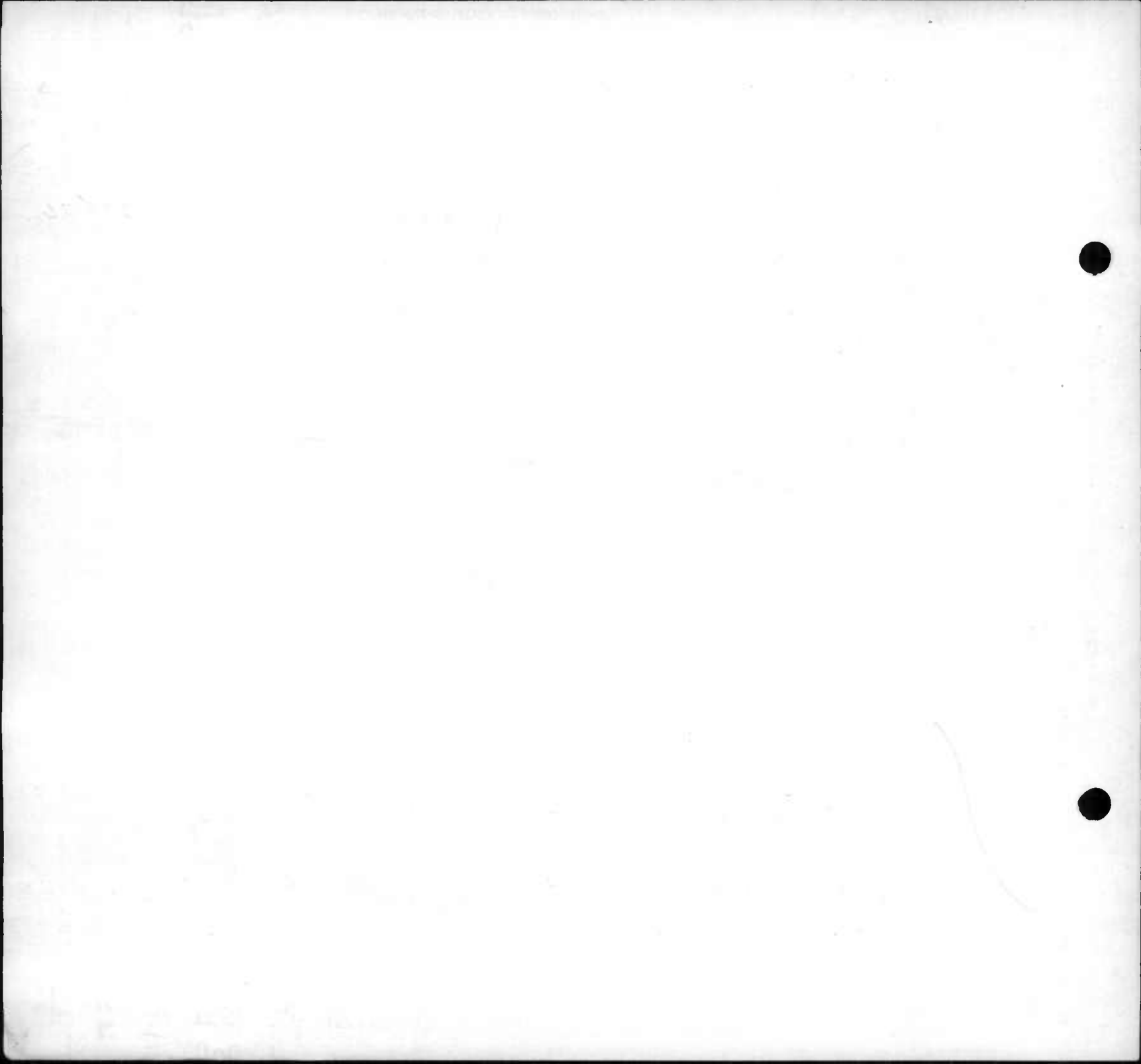
B-550		68 1046		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68 1046	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) BOWMAN, ROBERT			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH 500 A.M. 1/9/68 M.			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY HOSPITAL, UNIV. OF MD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MD B. COUNTY 22-07 C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 312 W Camden St			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/18/95	9. AGE (In years lost birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) UNKNOWN		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MRS BETTY CHASE - BALTO. CITY HOSP.			
18. 038.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Shock Sepsis, Pyelonephritis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 32 HRS			
19. 053.4 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from 1/7 19 68 to 1/9 19 68 , that (I) (we) last saw the deceased alive on 1/9/68 1230 AM 19 68 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ant P Seiger, MD				23B. DATE SIGNED 1/9/68		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) ANATOMY BOARD OF MARYLAND				23D. ADDRESS JOHNS HOPKINS MEDICAL SCHOOL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1-22-68		24C. NAME OF CEMETERY or CREMATION LOCATION HOSPITAL DISPOSAL		24D. ADDRESS	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1968		25B. NAME OF REGISTRAR Robert E. Galyan		25C. FUNERAL		25D. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 68 1047	
<div style="display: flex; justify-content: space-between;"> 7-432 68 1047 CERTIFICATE OF DEATH </div>					
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) Josephine Fletcher			2. DATE AND HOUR OF DEATH 6 Jan 1968 4:00 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Balto		
FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hspt.			C. CITY OR TOWN (If outside city limits, write RURAL and give township) 18-01		
			D. STREET ADDRESS (If rural, give location) 956 Franklin St. 2nd floor		
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) unknown	8. DATE OF BIRTH unknown	9. AGE (In years, last birthday) 64?	10. AGE (In years, last birthday) 64?
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10B. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) unknown	
12. CITIZEN OF WHAT COUNTRY? unknown					
13. FATHER'S NAME unknown			14. MOTHER'S MAIDEN NAME unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Josephine Marion Worthan	
				ADDRESS Same	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) myocardial infarction			CAUSE OF DEATH (A) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. anticoagulant cardiac vascular disease			(B) DUE TO		
			(C) DUE TO		
19. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH ?		
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) None		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5 Jan 1968 to 6 Jan 1968 , that (I) (we) last saw the deceased alive on 6 Jan 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Francis D. Drake M.D.				23B. DATE SIGNED 6 Jan 1968	
23C. PHYSICIAN'S NAME (Type) Francis D. Drake M.D.				23D. ADDRESS University Hspt	
24A. BURIAL CREMATION, REMOVAL (Specify) 1-18-68		24B. DATE 1-18-68		24C. NAME OF CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL HOSPITAL DISPOSAL	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1968		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR UNIVERSITY MEDICAL SCHOOL HOSPITAL DISPOSAL	



E-350

68 1048

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68 1048

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

SAM EATON

2. DATE
OF DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

1

17

68

10:15 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)

00

866 W. Fairmount St.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

January

17

1968

10:15 a.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Baltimore

YES ☒NO ☐

6. SEX

Male

7. RACE

Colored

B. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

10. AGE (In years
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

866 W. Fairmount St. Ave

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Arteriosclerotic Cardiovascular Disease

(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

4221

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

2

Partial

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

22F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 17, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

1-23-68

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

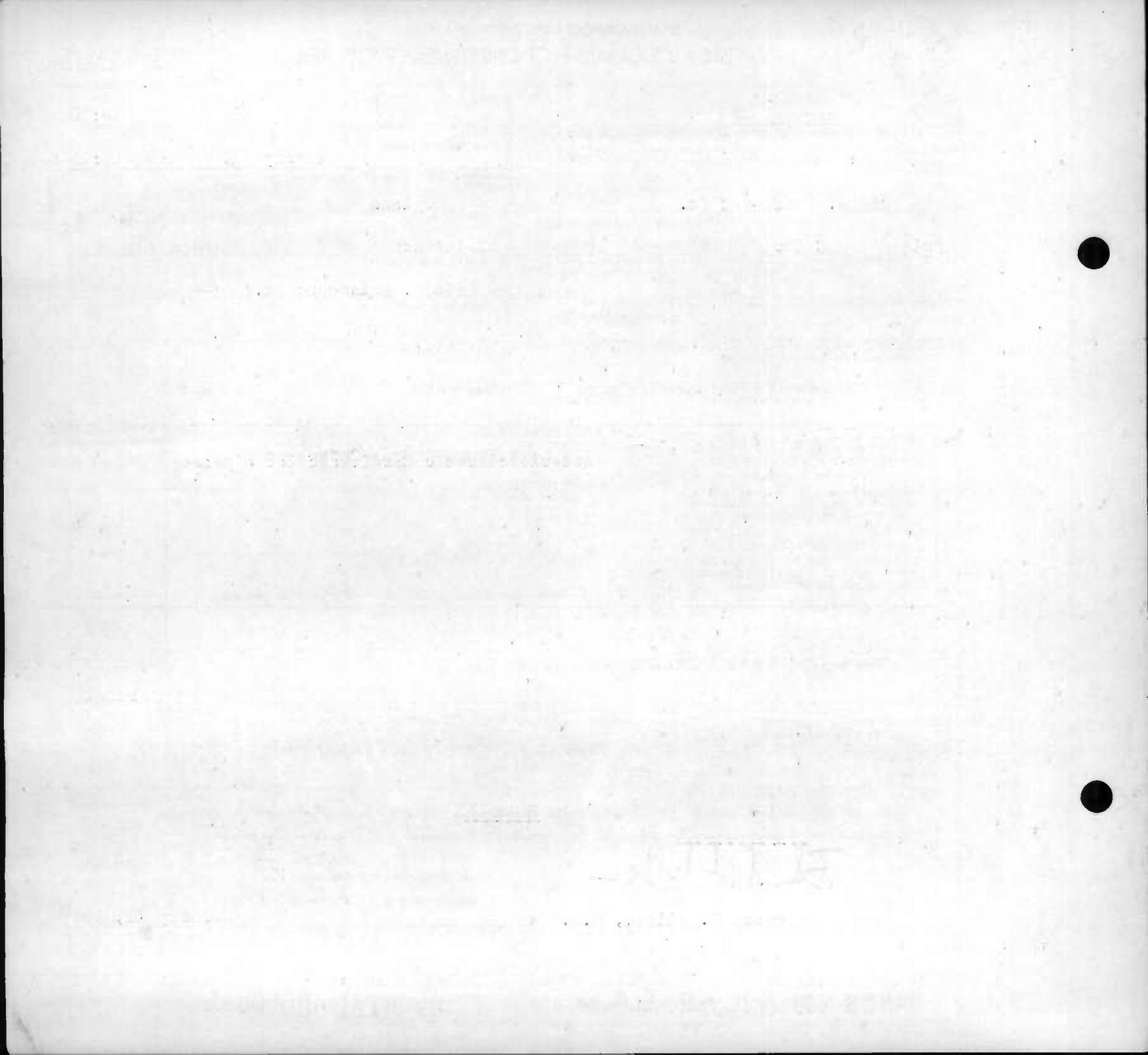
25C. FUNERAL DIRECTOR

ADDRESS

JAN 26 1968

Robert E. Fairbanks

HOSPITAL DISPOSAL

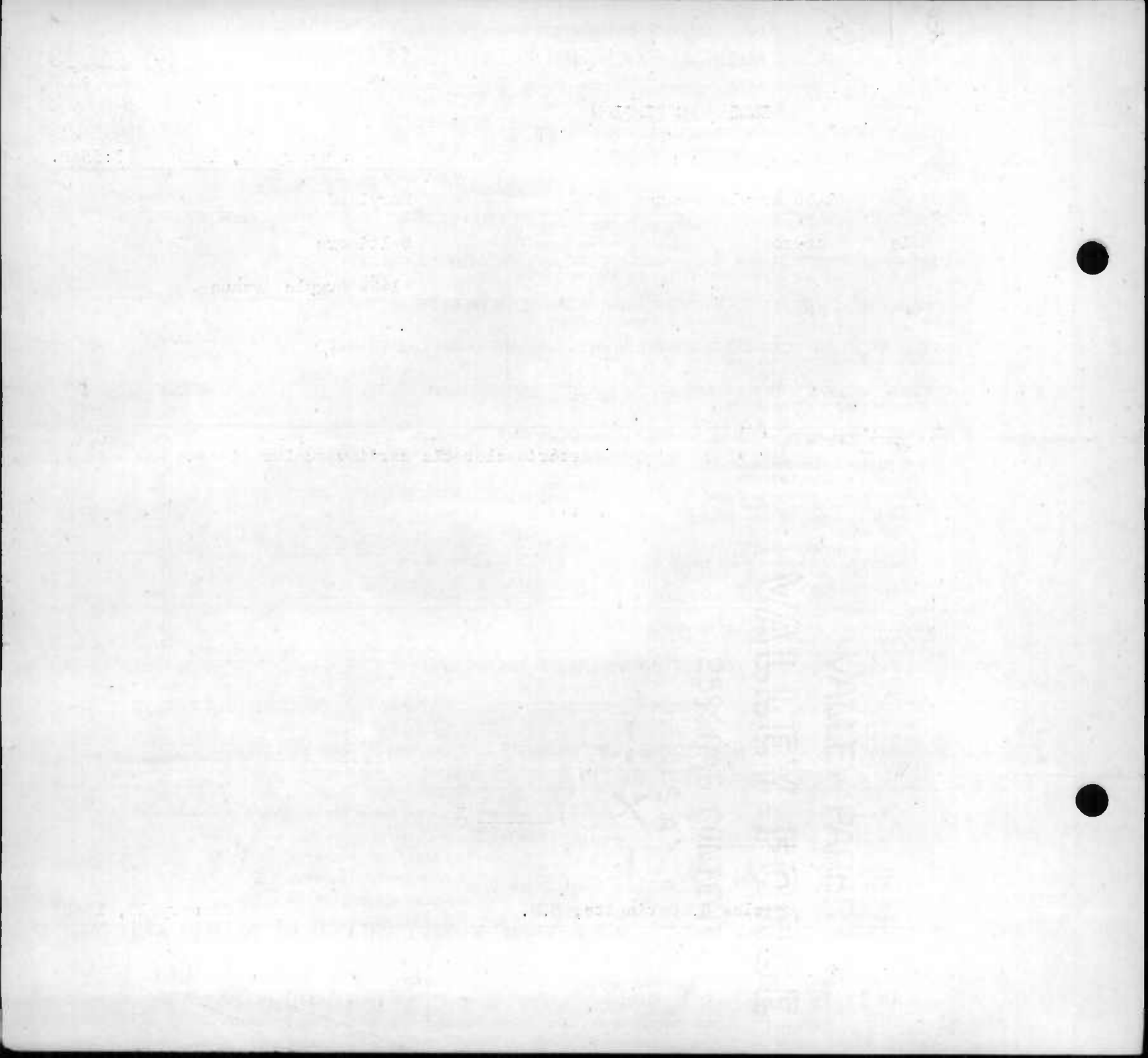


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68 1049

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM MC KINNION		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1426 Argyle Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour January 12, 1968 7:55 P.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH	10. AGE (In years last birthday) 43	11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. 412.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED January 13, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1-23-68	
24C. NAME OF CEMETERY OR CREMATOR		24D. LOCATION (City, town or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1968		25B. NAME OF REGISTRAR Robert E. Fairbank	
25C. FUNERAL DIRECTOR		25D. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 68-1050	
B-300 68-1050				BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <u>Irvin Boyd</u>				2. DATE AND HOUR OF DEATH <u>1/23/68</u> <u>150 P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>12-05</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University of Maryland Hospital</u>				C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>90E North Ave</u>							
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/10/00</u>	9. AGE (In years last birthday) <u>67</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>				11. BIRTHPLACE (State or foreign country) <u>Charles Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Samuel Boyd</u>				14. MOTHER'S MAIDEN NAME <u>Mamie?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Medicare 212 09 7768 A</u>		17. INFORMANT ADDRESS	
18. <u>250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Brain Stem Infarction</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerosis</u> (C) <u>Diabetes mellitus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>YRS</u> <u>YRS</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>260X II</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>1/23</u> 19 <u>68</u> to <u>1/23</u> 19 <u>65</u> , the (1) (we) last saw the deceased alive on <u>1/23</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Louis M. Miller</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1/23/68</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>Jan 27/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt Calvary</u>	
24D. LOCATION <u>Balto</u>				24E. (City, town, or county) (State) <u>MD</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1968</u>				25B. NAME OF REGISTRAR <u>Robert E. Faldut</u>		25C. FUNERAL DIRECTOR <u>W. Brooke Ruggals</u>	
				ADDRESS <u>1463 N. Carey St</u>			

W. L. G. W. L.
W. L. G. W. L.

W. L. G. W. L.
W. L. G. W. L.

W. L. G. W. L.
W. L. G. W. L.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-1051

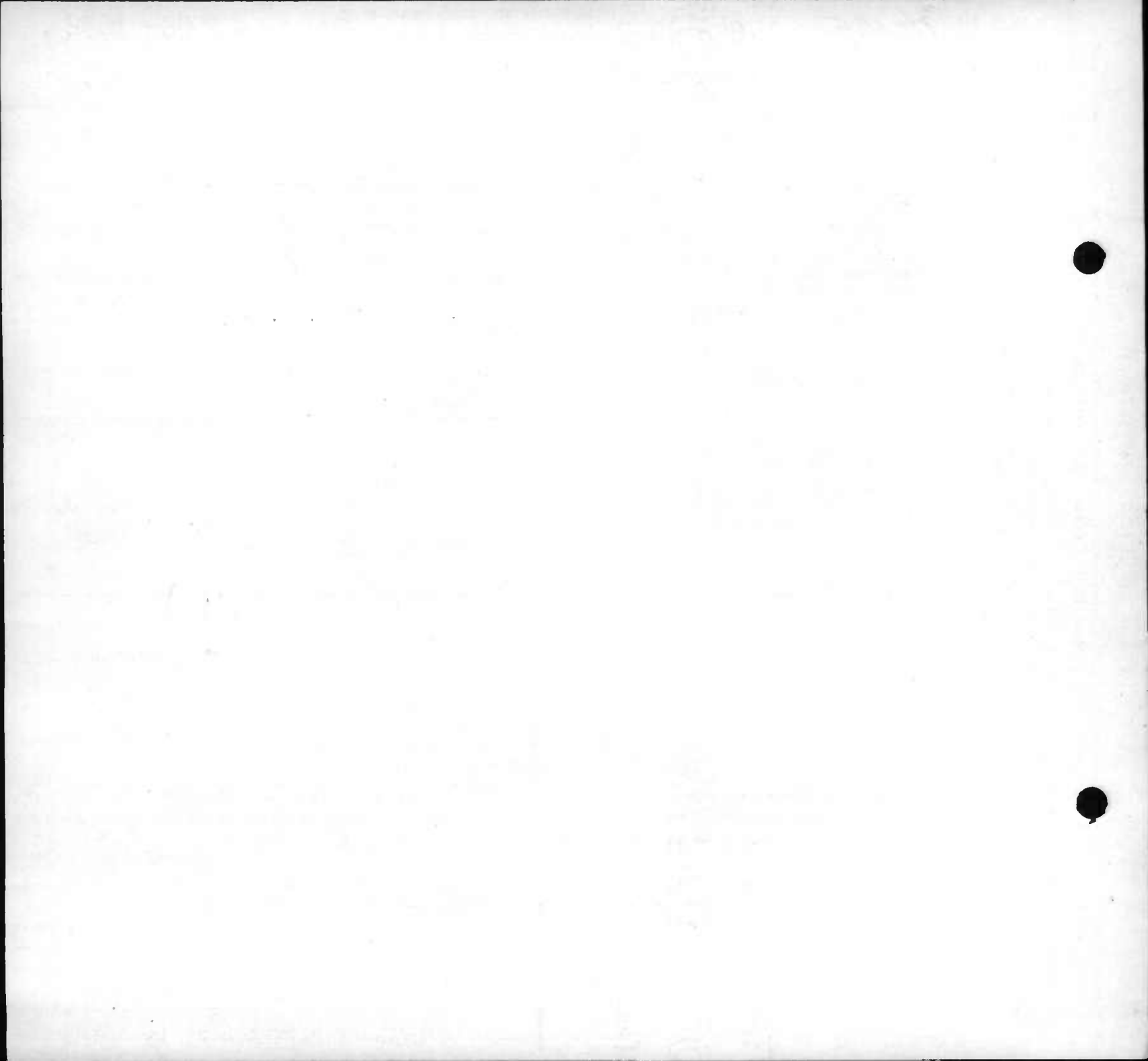
BIRTH NO.

1. NAME OF DECEASED (Type or Print) ROBERT LOUIS FARMER		2. DATE Known <input checked="" type="checkbox"/> Month Day Year OF DEATH Estimated <input type="checkbox"/> January 22, 1968 Hour 4:00 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 2502 Salem St. (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD January 22, 1968 Hour 4:00 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 13-03	
9. DATE OF BIRTH		10. AGE (In years lost birthday) 70	
11. BIRTH PLACE (State or foreign country) Charles Co Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Edward Farmer		14. MOTHER'S MAIDEN NAME Ellen ?	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		18. SOCIAL SECURITY NO. 219-12-7666	
19. 412.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic and Hypertensive (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiovascular Disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1/23/68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan 27/68	
24C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1968		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR V. Brooke Ruggles		25D. ADDRESS 14637 Carroll	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

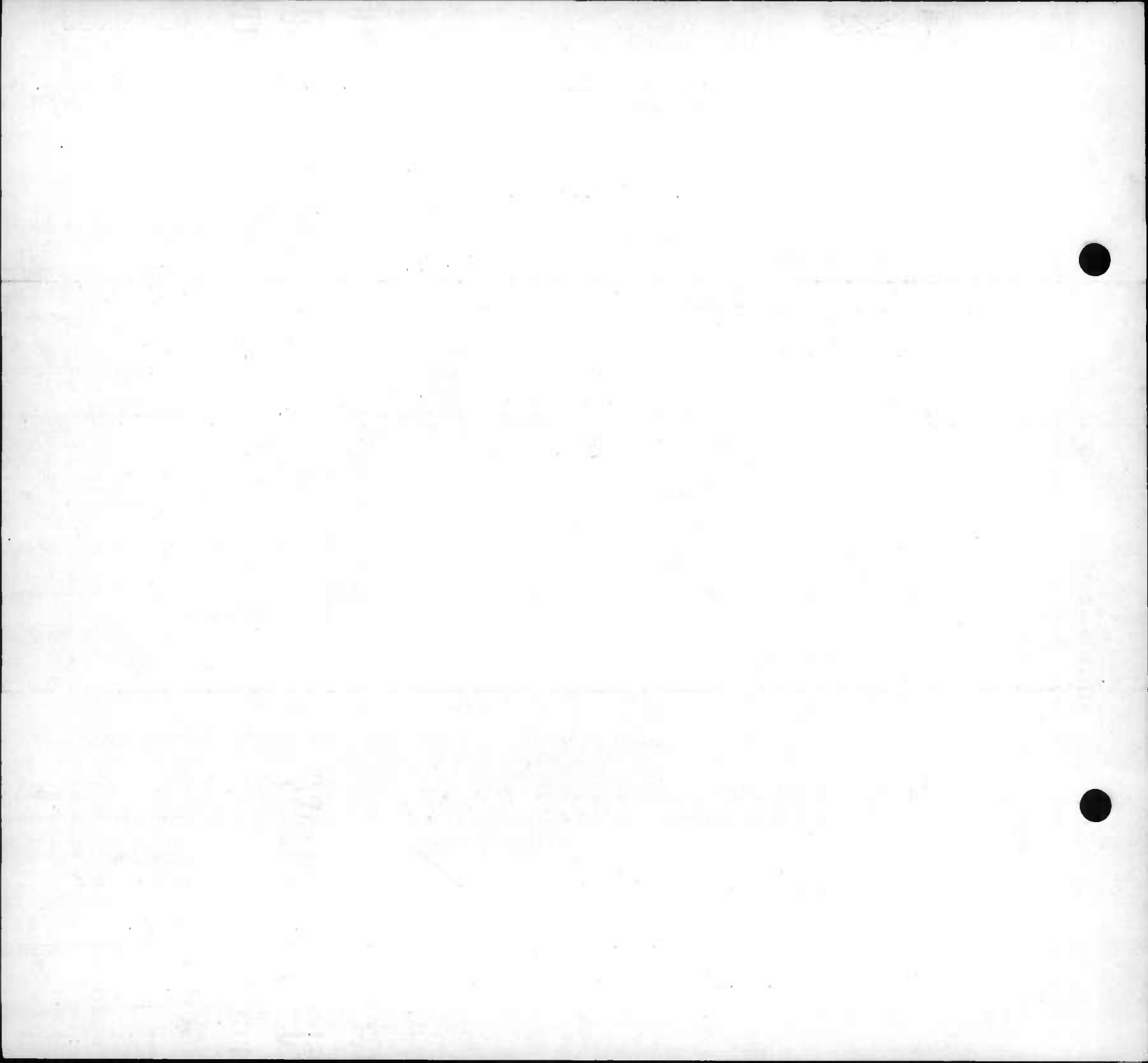
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1052	
BIRTH NO. H-125				68-1052	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) HOPKINS, LAURA B		2. DATE AND HOUR OF DEATH 1-24-68		6:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD UNION MEMORIAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-11			
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		C. CITY OR TOWN BALTIMORE 21218		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 4201 GREENWAY					
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-12-90	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Housewife		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Jersey City N. Jersey	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME JOSEPH R. BALDWIN		14. MOTHER'S MAIDEN NAME MARY JANE FARLEY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218 36 7851		17. INFORMANT Miles B. Hopkins (Son) Darlington Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 250.9 I		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary embolism? MI?			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 260X II		(B) DUE TO, OR AS A CONSEQUENCE OF: CHF & pulmonary edema			
		(C) Diabetes mellitus			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that (I) (this hospital) attended the deceased from Jan 17 19 68 to Jan. 24 19 68 . that (I) (we) lost saw the deceased olive on Jan. 24 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sargent Sifungkung, M.D.		23B. DATE SIGNED 12-24-68			
23C. PHYSICIAN'S NAME (Type) NORMAN FREEMAN		23D. ADDRESS Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 1/26/68	24C. NAME OF CEMETERY or CREMATORY Darlington Cemetery		24D. LOCATION (City, town, or county) (State) Darlington Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1968		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS INC. BALTIMORE MARYLAND 21213	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

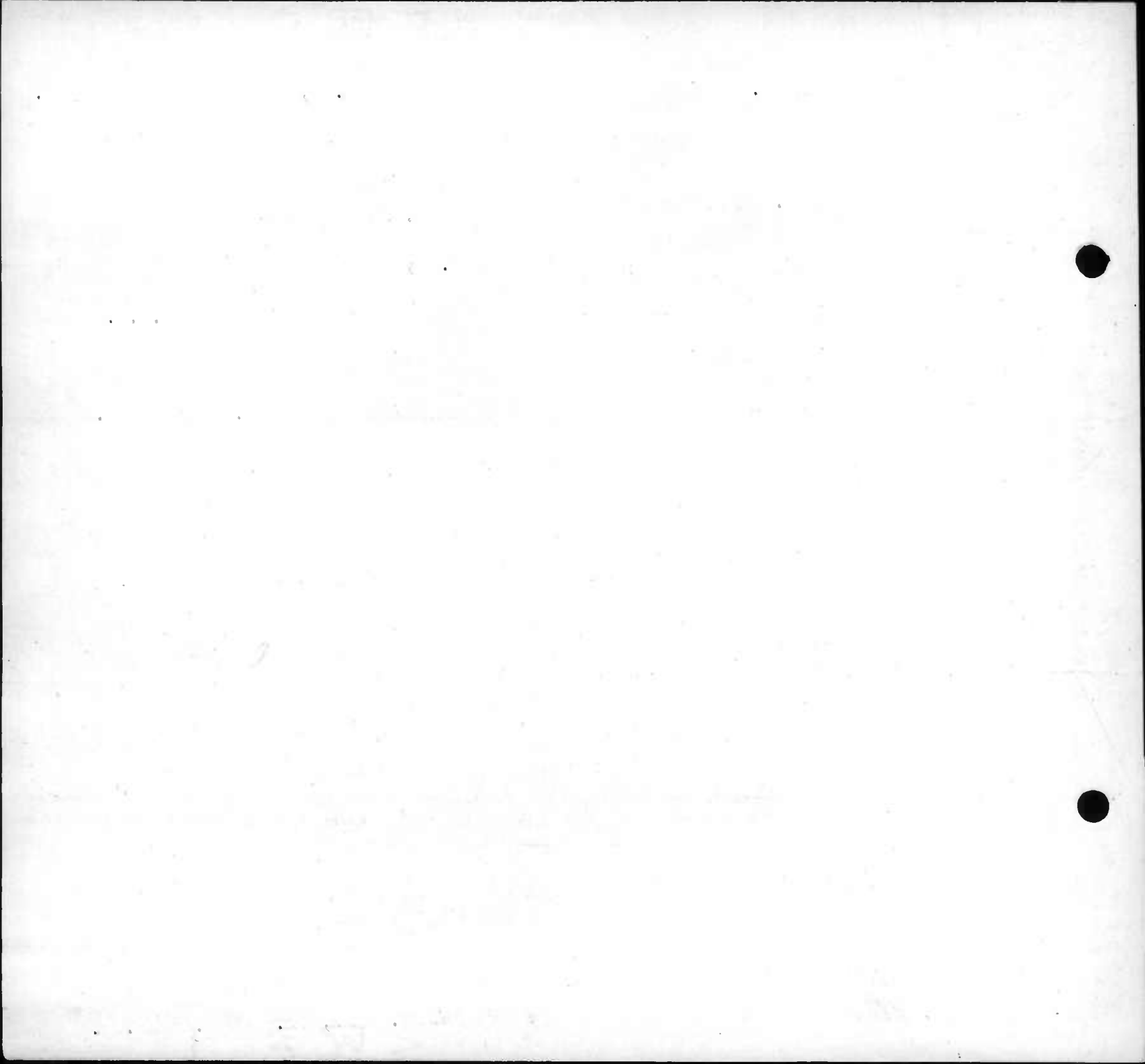
J-525		68-1053		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1053	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print)				BOYD LOUIS JOHNSON		2. DATE AND HOUR OF DEATH Jan. 24. 1968 4-15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
90 House in the Pines 5837 Belair Rd. Baltimore Md.				Baltimore 21206		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				3917 Marx Avenue			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
male	white			Apr. 21. 1903	64	Insurance Collector Retired	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Virginia				USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Charles Louis Johnson				Susie Parent			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no				215-01-6041A		Mrs. Vivian Johnson 3917 Marx Ave. Baltimore 21206	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH Squamous cell Carcinoma Rt. lung (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
19. DATE OF OPERATION				20. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				no			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-10-67 to 1-23 1968, that (I) (we) last saw the deceased alive on 1-23 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Sebb Russo				1-24-68			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
SEBASTIAN RUSSO M. D.				5017 Harford Rd. Baltimore Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial				Jan. 27. 1968		Parkwood Cemetery	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 26 1968				Robert E. Farber, Jr.		HENRY SANDER & SONS, INC Baltimore Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

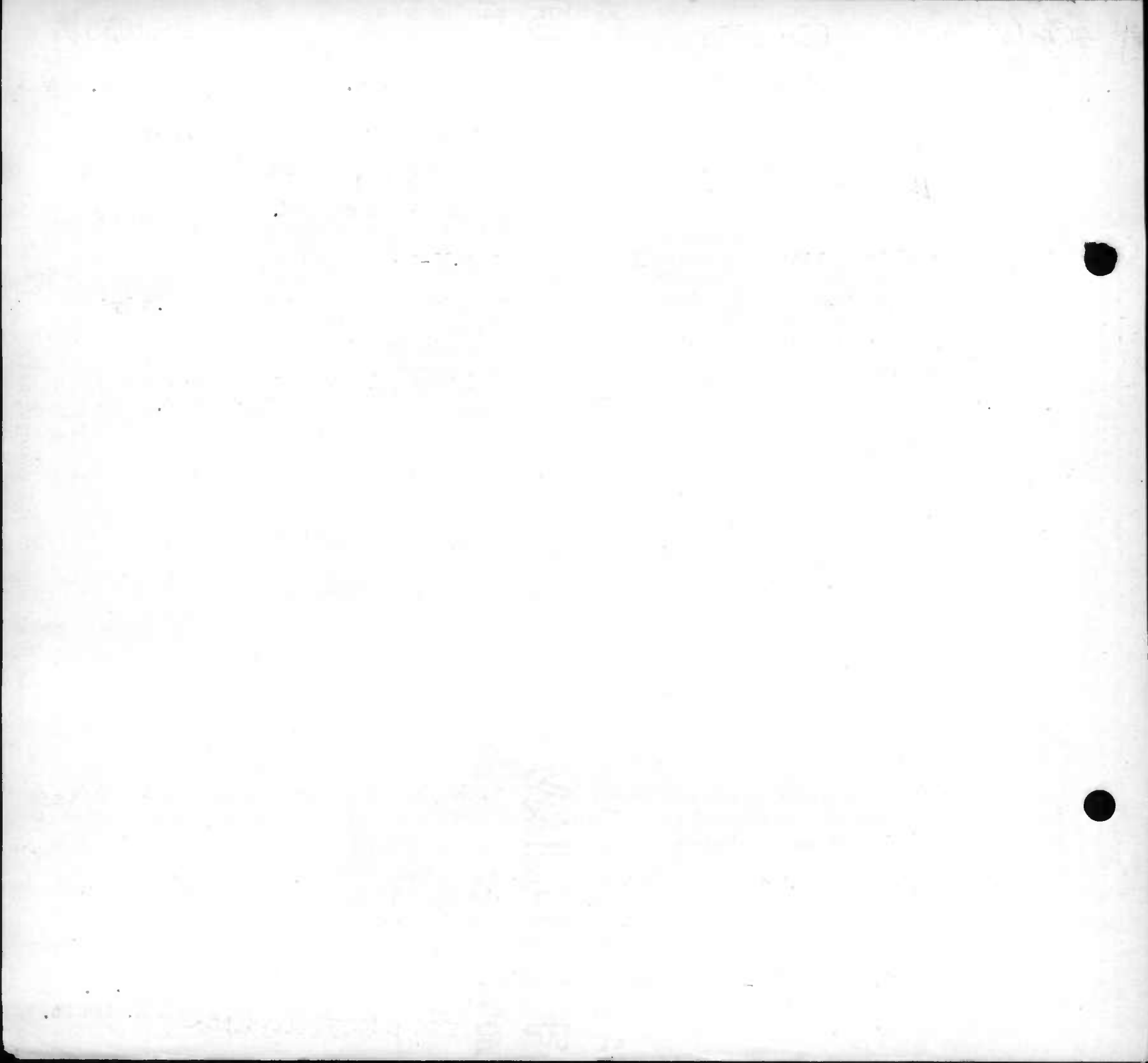
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-1054</u>
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>Anna C. Quinn</u>		2. DATE AND HOUR OF DEATH <u>Jan. 24, 1968</u> <u>5 P.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>827 S. Ellwood Avenue</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1-01</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>827 S. Ellwood Avenue</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 24, 1876</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		9. AGE (In years last birthday) <u>91</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>John Patrick Holland</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Cloney</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Jean Seidenzahl</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>420.1 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>None</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Acute Coronary Thrombosis</u> <u>Arteriosclerotic C.V. Disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1-15-68</u> <u>1-15-68</u> <u>2</u>
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u>		20A. AUTOPSY? (Yes or No) <u>None</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>None</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>None</u>
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u>None</u>		21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>None</u>
22. I certify that (I) (this hospital) attended the deceased from <u>Oct 15 1966</u> to <u>Jan 24 1968</u> , that (I) (we) last saw the deceased alive on <u>Jan 24 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE <u>E. G. Schimunek M.D.</u>			23B. DATE SIGNED <u>1-26-68</u>	
23C. PHYSICIAN'S NAME (Type) <u>EMMANUEL A SCHIMUNEK MD</u>			23D. ADDRESS <u>842 J. EAST AVE BALTIMORE, MD.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/27/68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1968</u>		
25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR <u>John A. Moran, Inc. 3000 E. Balto. St.</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

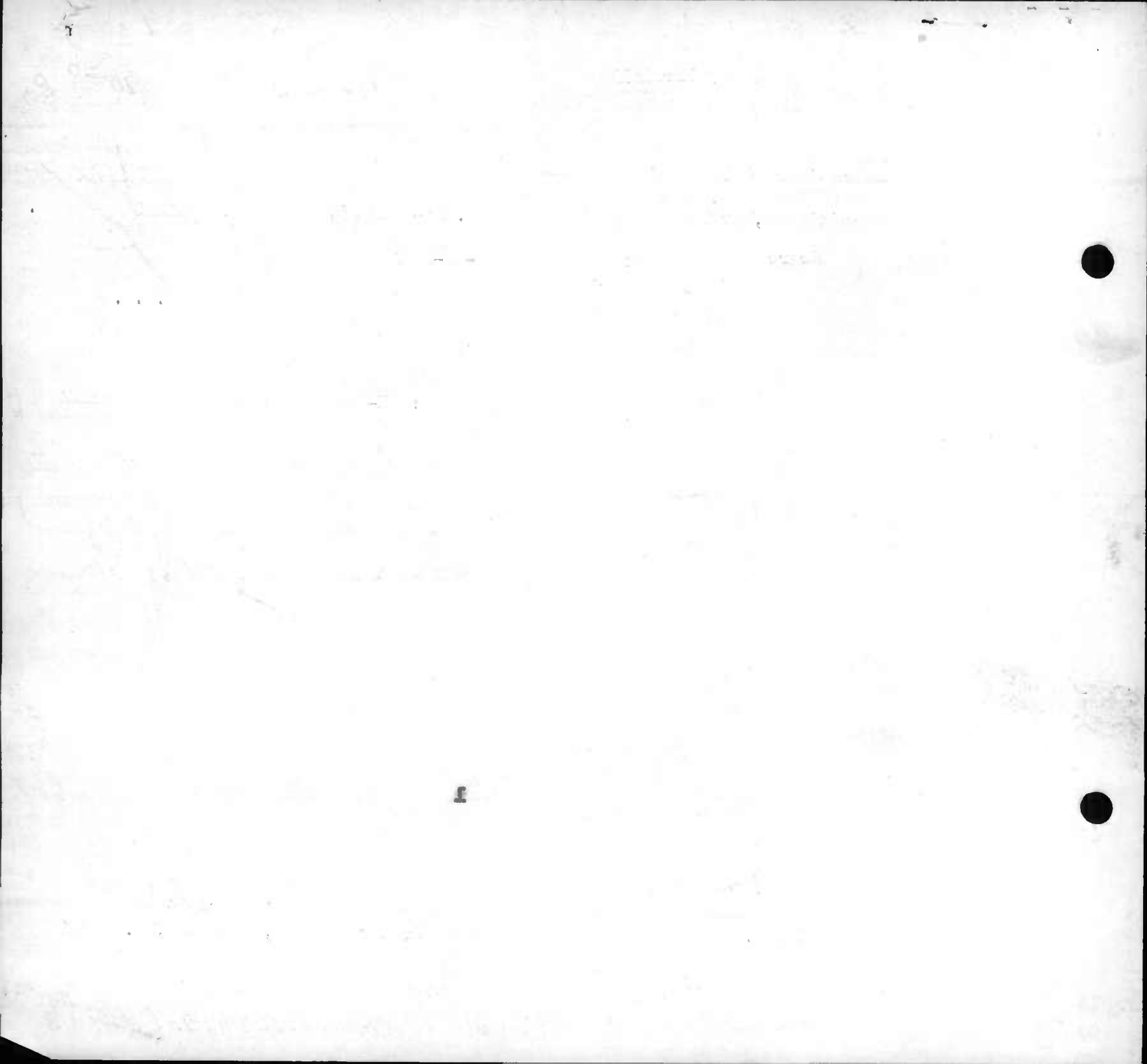
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1055	
68-1055				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MARY ANN or MARIANNA PELLEGRINO		2. DATE AND HOUR OF DEATH Jan. 23 1968 9.05 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY AA			
FULL NAME OF HOSPITAL OR INSTITUTION 34 BON SECOURS HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER Box 344 Pasadena Md.		52-00	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11-1894	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? Italy		13. FATHER'S NAME John Piraino		14. MOTHER'S MAIDEN NAME Maria Torchia	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Alfonso Pellegrino 19 Setter Drive Elkridge Md.	
18. 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 153.8 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic Ca to Liver Stomach or Small intestine (B) Colon Cancer (C) 1-2 yr.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 12 19 68 to Jan 23 19 68 , that (I) (we) lost saw the deceased alive on Jan 23 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Yong Cho		23B. DATE SIGNED Jan 23, '68		23C. PHYSICIAN'S NAME (Type) YONG CHO	
23D. ADDRESS Bon Secours Hosp. Baltimore		23E. FUNERAL DIRECTOR Frank Della Croce		23F. ADDRESS 322 S. High St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/27-68		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) 3801 Frederick Ave Bal. Md.		24E. DATE REC'D BY HEALTH DEPT. JAN 26 1968		24F. NAME OF REGISTRAR Robert E. Sall...	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

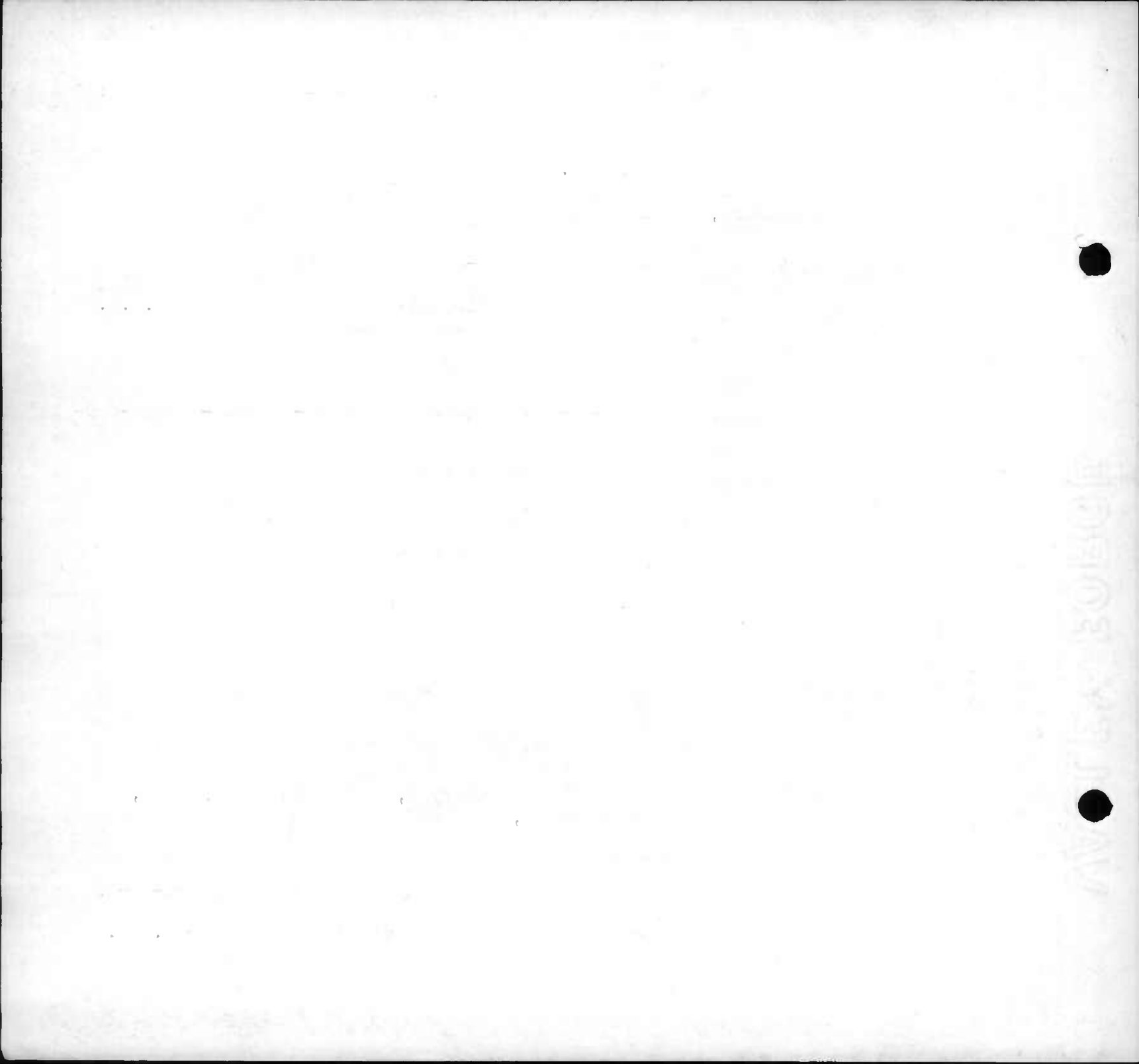
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		W		REG. NO. 68-1056	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Sydney Marshall		2. DATE AND HOUR OF DEATH 1/23/68		10 ²⁰ P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore					
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4940 Eastern Avenue		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Male		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-21-1883		9. AGE (In years last birthday) 84	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John				14. MOTHER'S MAIDEN NAME Rosie					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 717-10-8094		17. INFORMANT Records: BCH-4940 Eastern Avenue 21224					
18. 412.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Cardiac Arry Rhythm						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 minute	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Complete Heart Block						2-3 years	
		(B) DUE TO, OR AS A CONSEQUENCE OF: Atherosclerotic Heart Dis.						>10 years	
		(C) _____							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1/21 68 to 1/23 68 , that (I) (we) last saw the deceased alive on 1/23 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE David H. Huffman				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/23/68			
23C. PHYSICIAN'S NAME (Type) David H. Huffman				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/27/68		24C. NAME OF CEMETERY OR CREMATORY Int Calvary Cem		24D. LOCATION (City, town, or county) (State) Aa Co Ind			
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Robert E. Williams		ADDRESS 1701-3 N Bond St 21213			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. _____	
BIRTH NO. <u>10-425</u>		68-1057		CERTIFICATE OF DEATH	
M.E. CASE NO. _____		1. NAME OF DECEASED (Type or Print) <u>Nelson Ruth</u>		2. DATE AND HOUR OF DEATH <u>1-20-68</u> <u>3:10 A M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>39</u> <u>Provident Hospital Inc.</u> <u>1514 Division Street</u> <u>Baltimore, Maryland 21217</u>		A. STATE <u>Maryland</u> B. COUNTY _____			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>1410 McCulloh Street</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>-84</u>	9. AGE (In years last birthday) <u>89</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-56-4608</u>		17. INFORMANT <u>Theresa Bennett- Friend-</u> ADDRESS <u>Same-669-3158</u>	
18. <u>412.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Congestive Heart Failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic Heart Disease</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>January 3,</u> 19 <u>68</u> to <u>January 20,</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>January 20,</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Gregorio J. Teneco</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1-20-68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Gregorio J. Teneco</u>		23D. ADDRESS M.D. <u>1514 Division Street Balto. Md. 21217</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/24/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt Auburn Cemetery</u>	
24D. LOCATION <u>Baltimore Md</u>		24E. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1968</u>		24F. NAME OF REGISTRAR <u>Robert E. Falsky</u>	
24G. NAME OF REGISTRAR		24H. FUNERAL DIRECTOR <u>Joseph L. Russ</u>		24I. ADDRESS <u>2222 W. North Ave</u>	



OSL 2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1058	
BIRTH NO. 68-1058		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Annie R. Kenner		2. DATE AND HOUR OF DEATH 1/22/68 4:20 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL		A. STATE MARYLAND		B. COUNTY	
		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1538 POPLAR GROVE ST.			
5. SEX FEMALE	6. RACE NEGRO ID	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-5-29	9. AGE (In years last birthday) 38	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Northumberland, Virginia	
13. FATHER'S NAME ROBERT E. KENNER		14. MOTHER'S MAIDEN NAME BEATRICE LEE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Robert Kenner 1538 Poplar Grove Street	
18. 486X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week	
19. 493X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Achondroplasia			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/22 19 68 to 1/22 19 68, that (I) (we) last saw the deceased alive on 1/22 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dudley D. Goulden M.D.				23B. DATE SIGNED 1/22/68	
23C. PHYSICIAN'S NAME (Type) DUDLEY D. GOULDEN, M.D.				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan. 13, 1968		24C. NAME OF CEMETERY or CREMATORY Shiloh Bapt. Ch. Cemetery	
24D. LOCATION Northumberland (Burgess), Va.		25A. DATE REC'D BY HEALTH DEPT. JAN 26 1968			
25B. NAME OF REGISTRAR Robert E. Jenkins, M.D.		25C. FUNERAL DIRECTOR Joseph L. Kinn 2222 W. North Ave. Baltimore, Md.			

XX

XX

XX

XX

XX

XX

XX

XX

C-434		68-1059		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		68-1059	
BIRTH NO.		REG. NO.							
1. NAME OF DECEASED (Type or Print) BEULAH CALDWELL				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 23 68 2:40 p.m.					
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital D.O.A.				3. DATE PRONOUNCED DEAD Month Day Year Hour January 23 1968 2:40 p.m.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-11			
6. SEX Female	7. RACE Colored	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH Oct 5, 1891		10. AGE (In years lost birthday) 74		E. STREET AND NUMBER 3704 Sequoia Ave.					
11. BIRTHPLACE (State or foreign country) St. Michaels Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Chaney					
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Eugenia Fields					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 239-03-3853		18. INFORMANT ADDRESS Mrs Leona Chaney Adams 3704 Sequoia Ave					
19. 412.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
				(B) DUE TO, OR AS A CONSEQUENCE OF:					
				(C) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 422.1 II									
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?					
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Edward F. Wilson, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED January 23, 1968 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-27-68		24C. NAME OF CEMETERY or CREMATORY Arbutus Men Cem		24D. LOCATION (City, town, or county) (State) Arbutus Md			
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Joseph L. Ross		ADDRESS 2222 W. North Ave			

WALLISY POLICE

CHIEF OF POLICE

1911

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-1060

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CARRIE FREEMAN

2. DATE OF DEATH Known ☒ Month Day Year Hour
Estimated ☐ 1 22 68 1:00 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

60 1735 N. Pulaski St.

3. DATE PRONOUNCED DEAD Month Day Year Hour
January 22 1968 1:00p M.5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

6. SEX

Female

7. RACE

Colored

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

10. AGE (In years lost birthday)

67

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1735 N. Pulaski St.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Mrs. Blanche McKing 1735 Pulaski St.

19. 412.9 I

CAUSE OF DEATH

Arteriosclerotic Cardiovascular Disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 22, 1968

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

January 26, 1968

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cemetery

24D. LOCATION (City, town, or county) (State)

Westport (Baltimore) Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 26 1968

25B. NAME OF REGISTRAR

Robert E. Finkbeiner

25C. FUNERAL DIRECTOR

Joseph L. Duss 2222 N. North Ave.

ADDRESS

0-350

68-1061

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-1061

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

CHARLES CLAY ODOM

2. DATE OF DEATH

Known ☒ Estimated ☐

Month Day Year Hour

1

24

68

5:10 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

31

City Hospital

3. DATE PRONOUNCED DEAD

Month Day Year Hour

January

24

1968

5:10a.m.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

6. SEX

Male

7. RACE

Colored

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

4-2-1911

10. AGE (In years lost birthday)

56

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

2401 Ruth Ave.

53-00

11. BIRTHPLACE (State or foreign country)

Bamberg, S. Carolina

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

unk.

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Custodian

14B. KIND OF BUSINESS OR INDUSTRY

Dep't. of Education

15. MOTHER'S MAIDEN NAME

unk.

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL SECURITY NO.

248-36-3134

18. INFORMANT

ADDRESS

Mrs. Maude Jeter 2313 Ruth Ave. 21219

412.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

422.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 24, 1968

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1-29-68

24C. NAME OF CEMETERY or CREMATORY

Mt. Calvary Cemetery

24D. LOCATION (City, town, or county)

A.A. Co., Maryland

25A. DATE REC'D BY HEALTH DEPT.

JAN 28 1968

25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

1735 Harford Ave. 21213
Marshall W. Jones, Jr.

1911

1912

1913

1914

1915

1916

1917

1918

1919

1920

1921

1922

1923

1924

1925

1926

1927

1928

1929

1930

1931

1932

1933

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-1062 CERTIFICATE OF DEATH

REG. NO.

68-1062

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

John E. Usko

2. DATE AND HOUR OF DEATH

1-24-68 2:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

43 South Baltimore General Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY 26-05
C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES ☐ NO ☐

E. STREET AND NUMBER

636 Rappolla St.

5. SEX

M

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

5-13-1915

9. AGE (In years last birthday)

52

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Supervisor Burning & Welding Bethlehem

10B. KIND OF BUSINESS OR INDUSTRY

Pennsylvania

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Andrew Usko

14. MOTHER'S MAIDEN NAME

Dorothy Semanick

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

208-03-0945

17. INFORMANT

Mrs. Mary Usko

ADDRESS

636 S. Rappolla Street

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

Cerebral Anoxia

(B) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21E. INJURY OCCURRED While At ☐ Not While At Work ☐

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from 1-24 19 68 to 1- 19 68, that (we) last saw the deceased alive on 1-24 19 68 and that in (our) (aur) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Camile C. Balacuit

23B. DATE SIGNED

1/24/68

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23C. PHYSICIAN'S NAME (Type)

Camile C. Balacuit, Jr.

23D. ADDRESS

1213 Light St.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1-29-1968

24C. NAME OF CEMETERY or CREMATORY

St. Stanislaus

24D. LOCATION

Baltimore, Maryland

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 26 1968

25B. NAME OF REGISTRAR

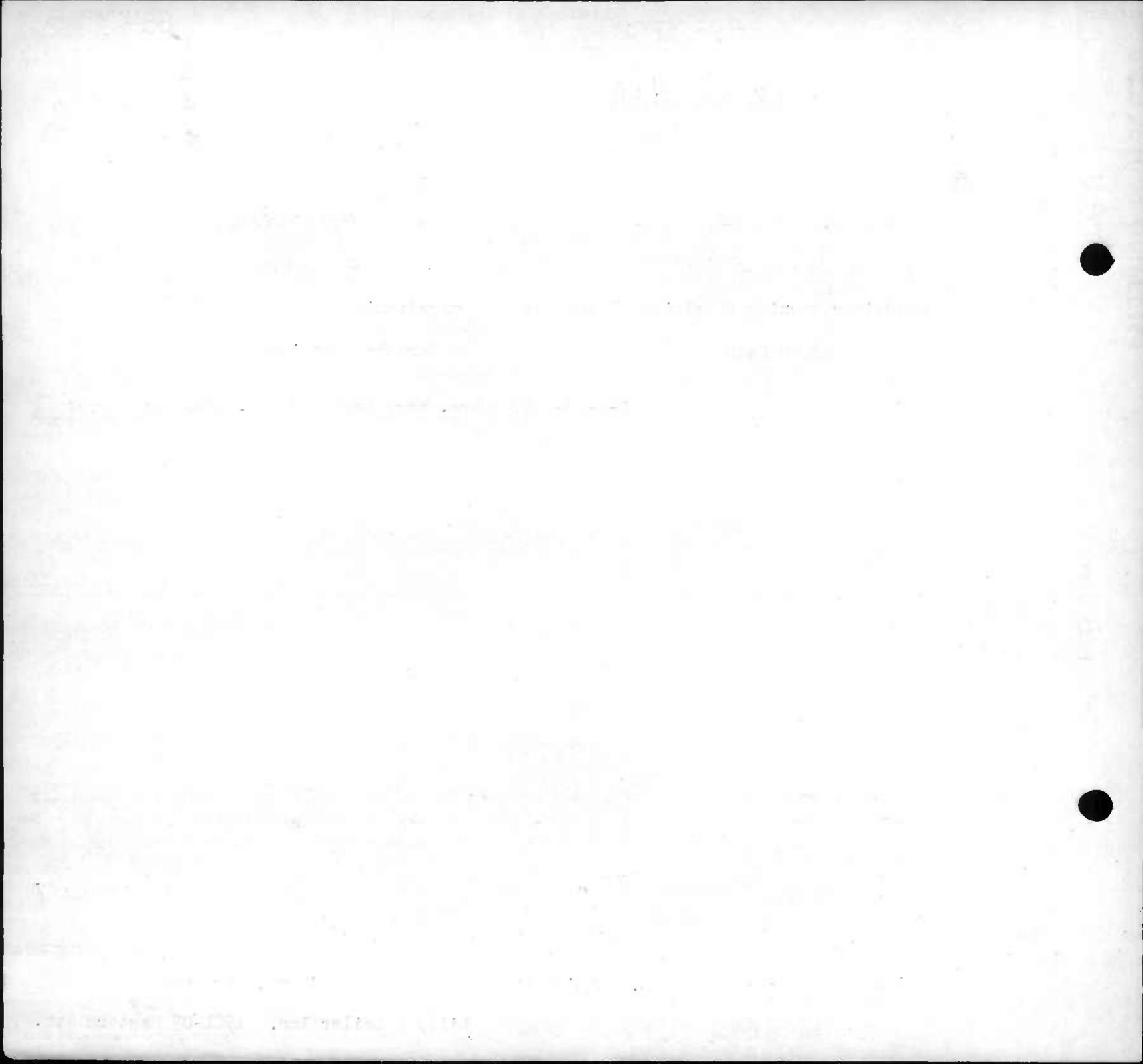
John E. Usko

25C. FUNERAL DIRECTOR

Lilly & Zeiler Inc.

ADDRESS

1901-07 Eastern Ave.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-623		68-1063		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1063		
BIRTH NO.				2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) CATHERINE M. CHRISTENSEN				1-24-68 3:30 P.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 31 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 315 INGLESIDE AVENUE 21228				
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-3-86	9. AGE (In years last birthday) 81	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME Barbara ?				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS BCH RECORDS: 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21221				
18. CAUSE OF DEATH 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 434.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MI (B) DUE TO, OR AS A CONSEQUENCE OF: CHF; PULM. EDEMA (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 10-14-1967 to 1-24-1968, that (I) (we) last saw the deceased alive on 1-24-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.								
23A. SIGNATURE Dowd J. Yaroborough				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) DOWD J. YAROBOROUGH		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-27-1968		24C. NAME OF CEMETERY or CREMATORY Mt. Carmel		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1968		25B. NAME OF REGISTRAR Robert E. Jarbo		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave.				



CERTIFICATE OF DEATH

REG. NO. 68-1064

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LILLIAN TAYLOR

2. DATE AND HOUR OF DEATH

JAN 22 1968 8 00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)31 Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN
Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1421 Ward Street 21229

5. SEX
Female6. RACE
Negro7. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

1-26-1911

9. AGE (In years
last birthday) 56If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laundress

10B. KIND OF BUSINESS OR INDUSTRY

Elite Laundry

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Houston

14. MOTHER'S MAIDEN NAME

Lottie Brown

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue 21224

18. 481X I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

probable Septicemia

12⁺ hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

pneumonia - pneumococcus

12⁺ hrs

(C) DUE TO, OR AS A CONSEQUENCE OF:

uremia

? 3 yrs

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

hypertensive CVD disease

? 3 yrs

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐ Not While
Work At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from JAN 18 1968 to JAN 22 1968,
that (I) (we) last saw the deceased alive on JAN 22 1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Fredy. Aoki MD

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

Jan 22 1968

23C. PHYSICIAN'S
NAME (Type)

Fred Aoki

23D. ADDRESS

Baltimore City Hospitals
4940 Eastern Avenue, Baltimore, Maryland24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE RECD BY HEALTH DEPT.

25B. NAME OF REGISTRAR

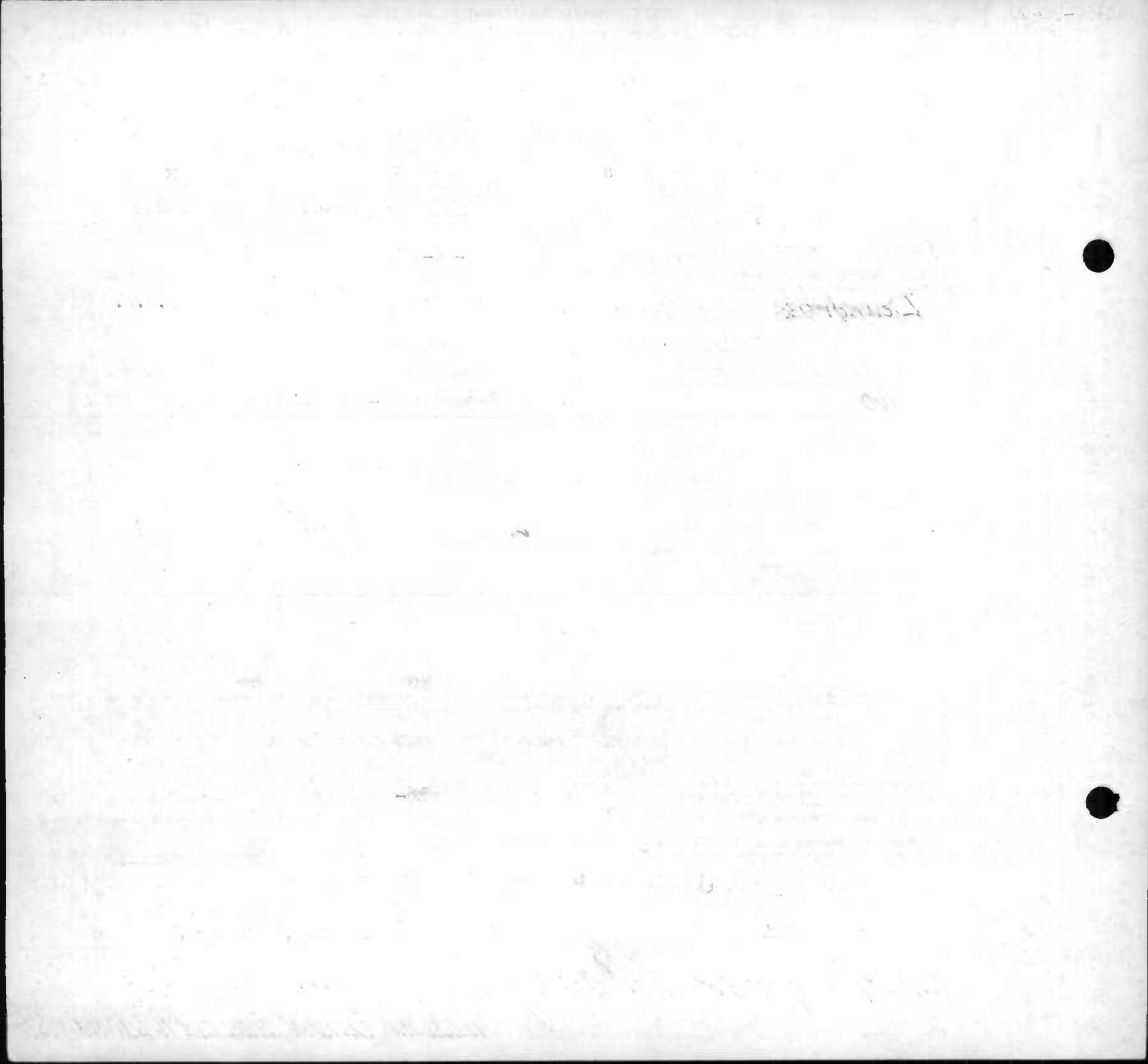
25C. FUNERAL DIRECTOR

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

24A. Burial 24B. 1/24/68 24C. Mt. Calvary Cem. 24D. Cedar Hill Mt.
25A. JAN 26 1968 25B. R.E. E. J. 25C. Williams Funeral Home 3197 Woodley St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1065 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 1065

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JACOBS, HUGH L. (Huey)

2. DATE AND HOUR OF DEATH

1-24-68 9:55 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

LUTHERAN HOSPITAL OF MD.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

728 N. MOUNT STREET

5. SEX

M

6. RACE

NEGRO

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

6-17-06

9. AGE (In years
last birthday)

62

If Under 1 Yr.
Months: Days:

If Under 24 Hrs.
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

laborer

10B. KIND OF BUSINESS OR INDUSTRY

Construction work

11. BIRTHPLACE (State or foreign country)

Bolton, North Carolina

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Daniel Jacobs

14. MOTHER'S MAIDEN NAME

Virginia Powell

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO.

16. SOCIAL
SECURITY NO.

—

17. INFORMANT

From chart.

ADDRESS

18. 134.1 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Carcinoma of Rectum

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

134X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-19-1968 to 1-24-1968,
that (I) (we) last saw the deceased alive on 1-24-1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

KHoo

Attending
Phys. ☐

Med.
Director ☐

Staff
Phys. ☒

23B. DATE SIGNED

1-24-1968

23C. PHYSICIAN'S
NAME (Type)

DAVID KHOO

23D. ADDRESS

LUTHERAN HOSPITAL OF MD.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1-24-68

24C. NAME OF CEMETERY or CREMATORY

Community Cem.

24D. LOCATION

Bolton,

(City, town, or county)

N.C

25A. DATE REC'D BY HEALTH DEPT.

JAN 26 1968

25B. NAME OF REGISTRAR

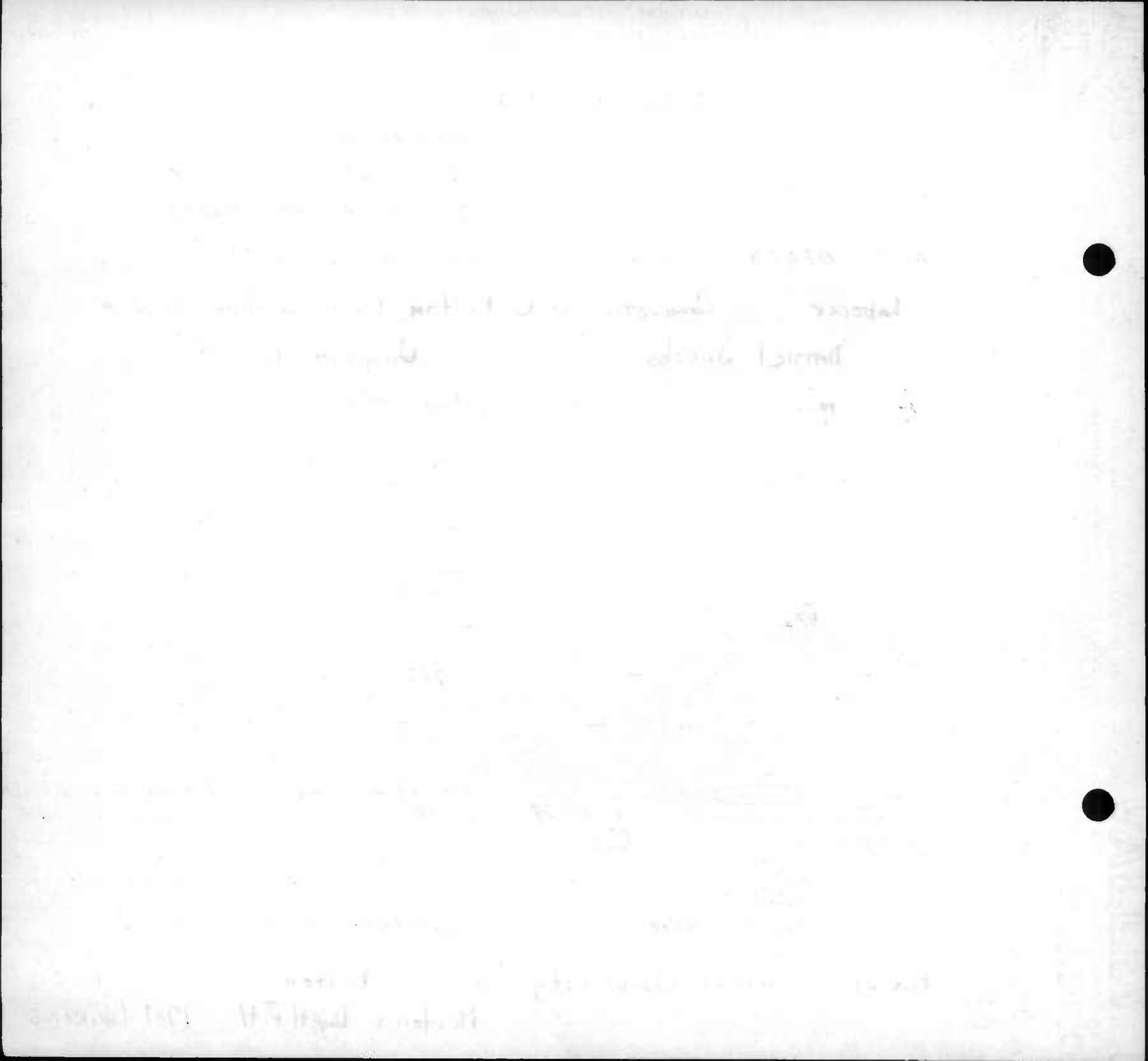
R. E. Feltner

25C. FUNERAL DIRECTOR

Morton E. Dyett F.T.H.

ADDRESS

1701 Laurens



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY AND COUNTY CERTIFICATE OF DEATH

REG. NO.

68-1066

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

PATE, VIOLA

2. DATE AND HOUR OF DEATH

1/25/68

5:30 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

LUTHERAN

HOSPITAL

OF MARYLAND

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MARYLAND

C. CITY OR TOWN BALTIMORE

E. STREET AND NUMBER

PULASKI ST. 619

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

5. SEX

FEMALE

6. RACE

COLOURED

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

11-13-18

9. AGE (In years last birthday)

49 YRS

If Under 1 Yr. Months: Days

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

COOK

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Wilson, North Carolina

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Pate

14. MOTHER'S MAIDEN NAME

Hellie R. Pate

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

243-03-0322

17. INFORMANT

Mr. Grant Pate

ADDRESS

2522 Woodbrook

18.

4310 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE HYPERTENSION WITH DUE TO, OR AS A CONSEQUENCE OF:

(B) INTRACEREBRAL HAEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from 1/24/68 19 to 1/25/68 19 that (we) last saw the deceased alive on 1/25/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

P. P. JOSHI

MD DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1/25/68

23C. PHYSICIAN'S NAME (Type)

P. P. JOSHI

MD DEGREE

23D. ADDRESS

730 ASHBURTON ST, BALTIMORE, 21216

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

1-28-68

24C. NAME OF CEMETERY OR CREMATORY

Union Bapt. Ch. Cem.

24D. LOCATION

Wilson

(City, town, or county)

N.C.

25A. DATE REC'D BY HEALTH DEPT.

JAN 26 1968

25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

Morton E. Dyett F.H.

ADDRESS

1701 Laurens

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

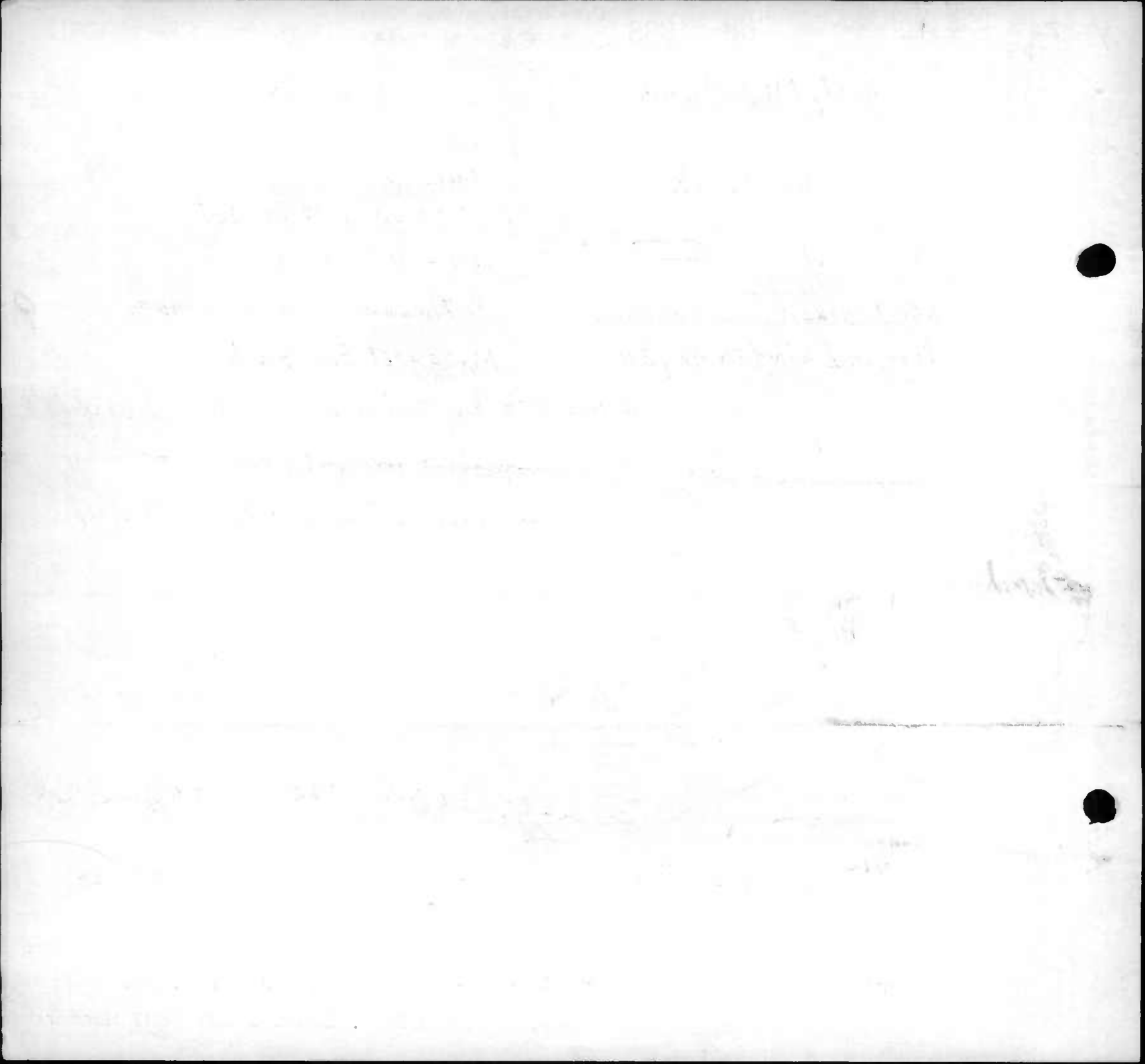
RELEASED AS NON-MEDICAL EXAMINER'S CASE, PER MR. HENRY FOR MEDICAL EXAMINER

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1067	
1. NAME OF DECEASED (Type or Print) <u>Jenkins, Wilford</u>		2. DATE AND HOUR OF DEATH <u>1-25-68</u> <u>1:20 A.</u> M.		OSL <u>6</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>12 BALTIMORE CITY</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 Johns Hopkins Hospital</u>		C. CITY OR TOWN <u>BALTIMORE</u> INSIDE CITY LIMITS? <u>YES</u> <input checked="" type="checkbox"/> <u>NO</u> <input type="checkbox"/>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>208 N. GILMORE STREET</u> <u>21223</u>			
5. SEX <u>MALE</u>	6. RACE <u>COLORED</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-24-25</u>	9. AGE (In years last birthday) <u>42</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>WILLIE JENKINS</u>		14. MOTHER'S MAIDEN NAME <u>GEORGIA BROWN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-18-2714</u>		17. INFORMANT ADDRESS <u>Mrs. Elizabeth Jenkins 208 N Gilmon</u>	
18. <u>162.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>CARCINOMA METASTATIC</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>PROB. Lung Primary</u> DUE TO, OR AS A CONSEQUENCE OF: <u>6 MONTHS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>NO</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1-24</u> 19 <u>68</u> to <u>1-25</u> 19 <u>68</u> , that (I) (we) lost saw the deceased olive on <u>1-25</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Major Bradshaw M.D.</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1-25-68</u>	
23C. PHYSICIAN'S NAME (Type) <u>MAJOR BRADSHAW</u>		23D. ADDRESS <u>Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>1-27-68</u>	24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem. Park</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1968</u>	25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	25C. FUNERAL DIRECTOR <u>Morton E. Dyck F.H.</u>		ADDRESS <u>1701 Laurens</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>68-1068</u>	
BIRTH NO. <u>68-1068</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Host, MRS ANNA</u>		2. DATE AND HOUR OF DEATH <u>1-23-68</u> <u>5⁰⁵</u> <u>P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> 8. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>91</u> <u>KESWICK</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>700 W. 40th STREET</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED</u> , DIVORCED (specify)	8. DATE OF BIRTH <u>12-11-1888</u>	9. AGE (In years last birthday) <u>79</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHIRT-IRONER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>LAUNDRY</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Leonard LINDENMEYER</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET EVA BACH</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-03-3870</u>		17. INFORMANT <u>Lutacke R.N. Keswick (Records)</u>	
18. <u>412.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral hemorrhage</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic CVD</u> <u>2 yrs</u>		CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH			
19. <u>422.1 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>29 Nov 1965</u> to <u>23 Jan 1968</u> , that (I) (we) last saw the deceased alive on <u>23 Jan 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Harold P. Brene</u> M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>1-23-68</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE		24C. NAME OF CEMETERY or CREMATORY <u>Western Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore City, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1968</u>		25B. NAME OF REGISTRAR <u>Charles E. Fisher</u>		25C. FUNERAL DIRECTOR ADDRESS <u>CHARLES F. EVANS & SON 8802 Harford Rd</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1069	
BIRTH NO. 13-435				68-1069 CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		FRANK LEEDY BALDWIN		2. DATE AND HOUR OF DEATH 1-24-68 2:35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL				A. STATE MARYLAND	
(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY ST. MARY'S CO	
				C. CITY OR TOWN CALIFORNIA	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER Box 212	
				ZIP CODE 10417	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-19-99	9. AGE (In years lost birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) POCAHONTAS, VIRGINIA	
13. FATHER'S NAME D. O. BALDWIN		14. MOTHER'S MAIDEN NAME JENNIE LEEDY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) WW1		16. SOCIAL SECURITY NO. 223-26-1548		17. INFORMANT NORA M BALDWIN	
				ADDRESS Box 212 CALIFORNIA, MARYLAND	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 447.10 HEART FAILURE 1 1/2 days				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASPIRIN POISONING 2 days					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 457X II chronic lung disease					
19A. DATE OF OPERATION 1-19-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED acute abdominal surgery		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-6-68 to 1-24-68, that (I) (we) last saw the deceased alive on 1-24-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Antonio Gonzalez-Revilla Jr. M.D.				23B. DATE SIGNED 1-24-68	
23C. PHYSICIAN'S NAME (Type) Antonio Gonzalez-Revilla Jr. M.D.				23D. ADDRESS Johns Hopkins Hosp. Balto Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JAN. 17, 1968		24C. NAME OF CEMETERY OR CREMATORY TRINITY MEMORIAL GARDENS	
24D. LOCATION WALDORF, CHARLES, MARYLAND		24E. DATE REC'D BY HEALTH DEPT. JAN 26 1968		24F. NAME OF REGISTRAR Robert E. Farley	
24G. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		24H. LEONARDTOWN, MARYLAND			

X

Y

I

Y

I

- 22 -

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-1070 CERTIFICATE OF DEATH

REG. NO.

68-1070

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Kenley P. Lennon</i>		2. DATE AND HOUR OF DEATH <i>1-21-68 3:40 P</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>BALTO</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital Emergency Dept</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>BALTO</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>M</i>		6. RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>District Represent.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>ELECTRICAL</i>		8. DATE OF BIRTH <i>2-5-18</i>	
13. FATHER'S NAME <i>James P. Lennon</i>		14. MOTHER'S MAIDEN NAME <i>MARY BURNS</i>		9. AGE (In years lost birthday) <i>50 yrs</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WWII</i>		16. SOCIAL SECURITY NO. <i>218-01-0197</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
17. INFORMANT <i>Mildred Lennon</i>		ADDRESS <i>Same</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>412.1 I</i> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>422.1 II</i>				CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Coronary Arteriosclerotic CVD</i> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs +</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>June 1962</i> to <i>1-21 1968</i> , that (I) (we) last saw the deceased alive on <i>1-20 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Franklin E. Isler</i>				23B. DATE SIGNED <i>1/23/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>F</i>				23D. ADDRESS <i>DEGREE</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>1-24-68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>BALTIMORE NATIONAL</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTIMORE CITY, MD</i>		25A. DATE REC'D BY HEALTH DEPT. <i>1-24-68</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>	
25C. FUNERAL DIRECTOR <i>Enkus Funeral Home</i>		25D. ADDRESS <i>5892 Hartford Rd</i>			

192

Mr. Wm. H. ...
2-2-18 2000

Photograph of ...

... of the ...

... of the ...

...

...

...

...

...

...

...

...

...

...

...

K-552

68-1071

BALTIMORE CITY HEALTH DEPARTMENT

68-1071

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ALEXANDER KAMINSKI		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> January 24, 1968 Hour 12:50 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 35 Church Home & Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour January 24, 1968 12:50 P.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2-01			
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 12/17/96	10. AGE (In years last birthday) 71	E. STREET AND NUMBER 2042 Eastern Avenue	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		14B. KIND OF BUSINESS OR INDUSTRY Gen. Contractor	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I		17. SOCIAL SECURITY NO. 212-12-1716	
15. MOTHER'S MAIDEN NAME Valeria Gilczynski		18. INFORMANT ADDRESS Mr. Roman A. Kaminski, 2125 Eastern Ave	

MEDICAL CERTIFICATION	19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 422.7 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
	20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
	21. AUTOPSY? (Yes or No) No			
	22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
	22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
	22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
	22F. HOW DID INJURY OCCUR?			
	23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED January 25, 1968			
	24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/27/68	
	24C. NAME of CEMETERY or CREMATORY Holy Rosary		24D. LOCATION (City, town or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1968		25B. NAME OF REGISTRAR Robert E. Taylor		
25C. FUNERAL DIRECTOR M.F. SADOWSKI & SONS		ADDRESS 1808 Eastern Ave		

10:00 AM
10:00 AM

10:00 AM
10:00 AM
10:00 AM

10:00 AM
10:00 AM

MAILED
10:00 AM

10:00 AM
10:00 AM

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-1072

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CORA JAYROE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 21 68 10:05 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 35 Church Home and Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour January 21 1968 10:05 p.m.	
6. SEX Female		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY	
9. DATE OF BIRTH 7-21-1915		10. AGE (In years last birthday) 52	
11. BIRTHPLACE (State or foreign country) md		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME Mary Hebbard		18. INFORMANT Mrs. Mary Friese	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) II and III degree burns of 80% of body surface		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 1 21 68 4:05 p.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 828 S. Bond St.		22F. HOW DID INJURY OCCUR? Conflagration	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. AUTOPSY? (Yes or No) YES	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Edward F. Wilson, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-25-68	
24C. NAME OF CEMETERY or CREMATORY Mt. Carmel		24D. LOCATION (City, town, or county) (State) md	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1968		25B. NAME OF REGISTRAR Robert E. Farber	
25C. FUNERAL DIRECTOR Thelma A. Hoffmann		ADDRESS 3218 N. Linden St.	

Don't know where
it is. It is
in the house.

17th
March

180

17th
March

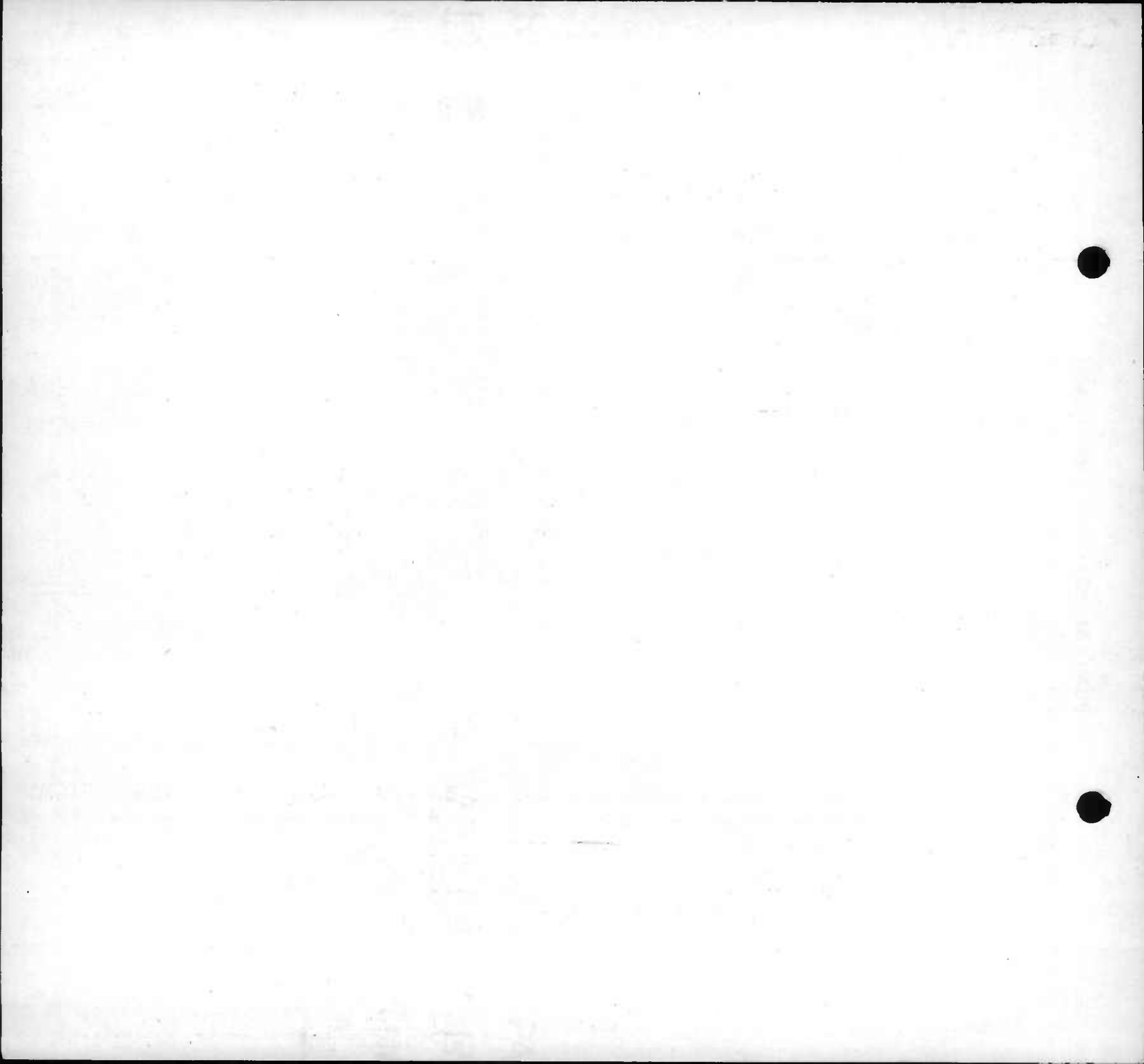
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-1073 CERTIFICATE OF DEATH

REG. NO. 68-1073

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Wilbur L. Demme		Jan. 24, 1968 8:30 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
102 N. Peca Street Baltimore, Md. 21201				Maryland	
				C. CITY OR TOWN	
				Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				515 Chateau Street	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Male	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Sept. 6, 1901	66	Conductor
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Conductor		Balto. Trans. Co.		Baltimore, Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Charles Wm. Demme			Eva Emerck		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No ---			213-10-0769A		Myrtle Demme W. 305 Madison St. (Sister)
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
331X II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from April 1, 1966 to Jan 24, 1968, that (I) (we) last saw the deceased alive on Jan 24, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Willard Applefeld				1/25/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Willard Applefeld				6615 Reistertown Road	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		Jan. 27/68		Loudon Park Cemetery	
24D. LOCATION		24E. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
Baltimore, Md.		Robert E. Farber		Eugenia K. Seitz 5209 York Rd. Seitz Funeral Home Balto. Md. 21212	



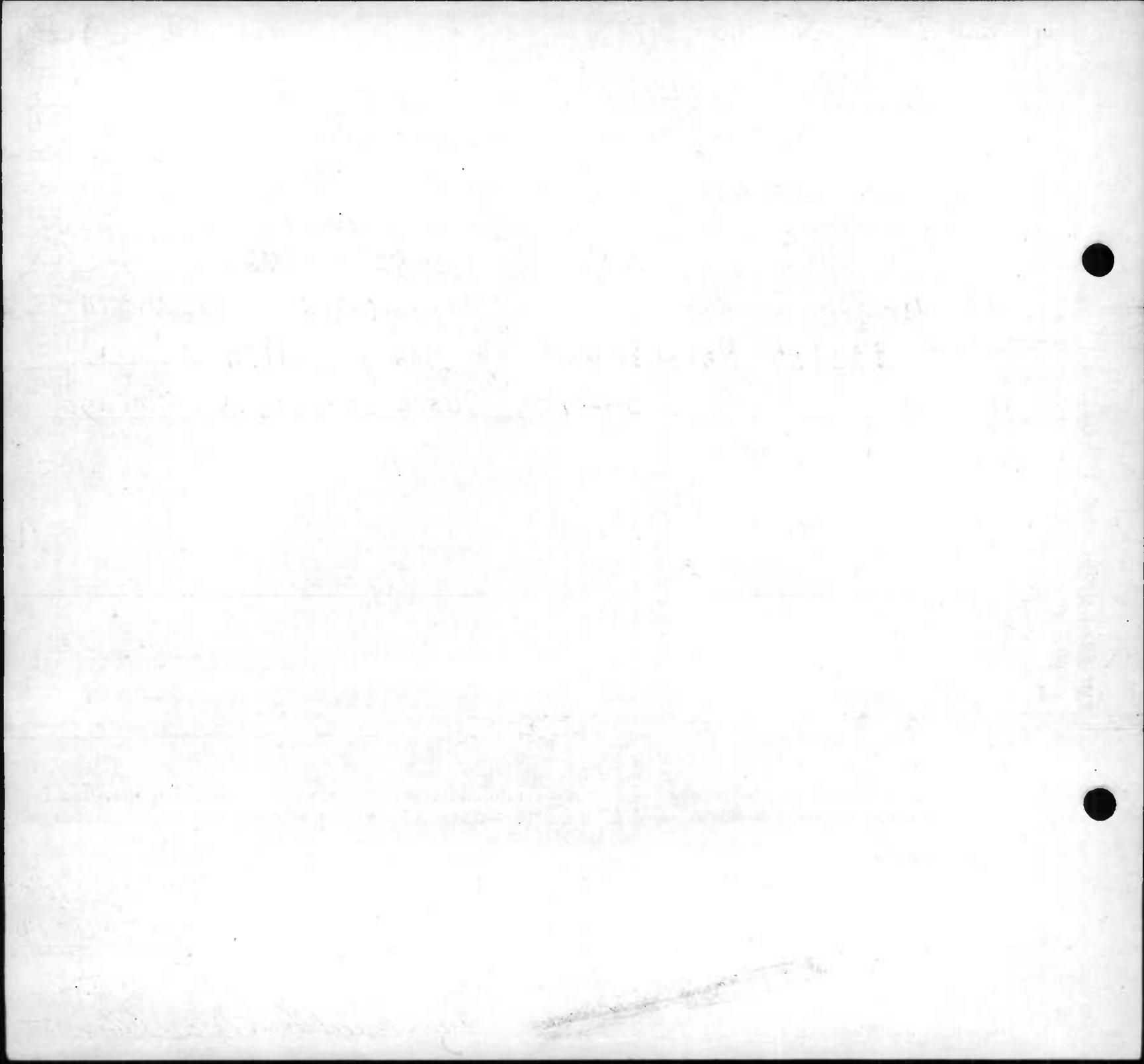
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 1074 CERTIFICATE OF DEATH

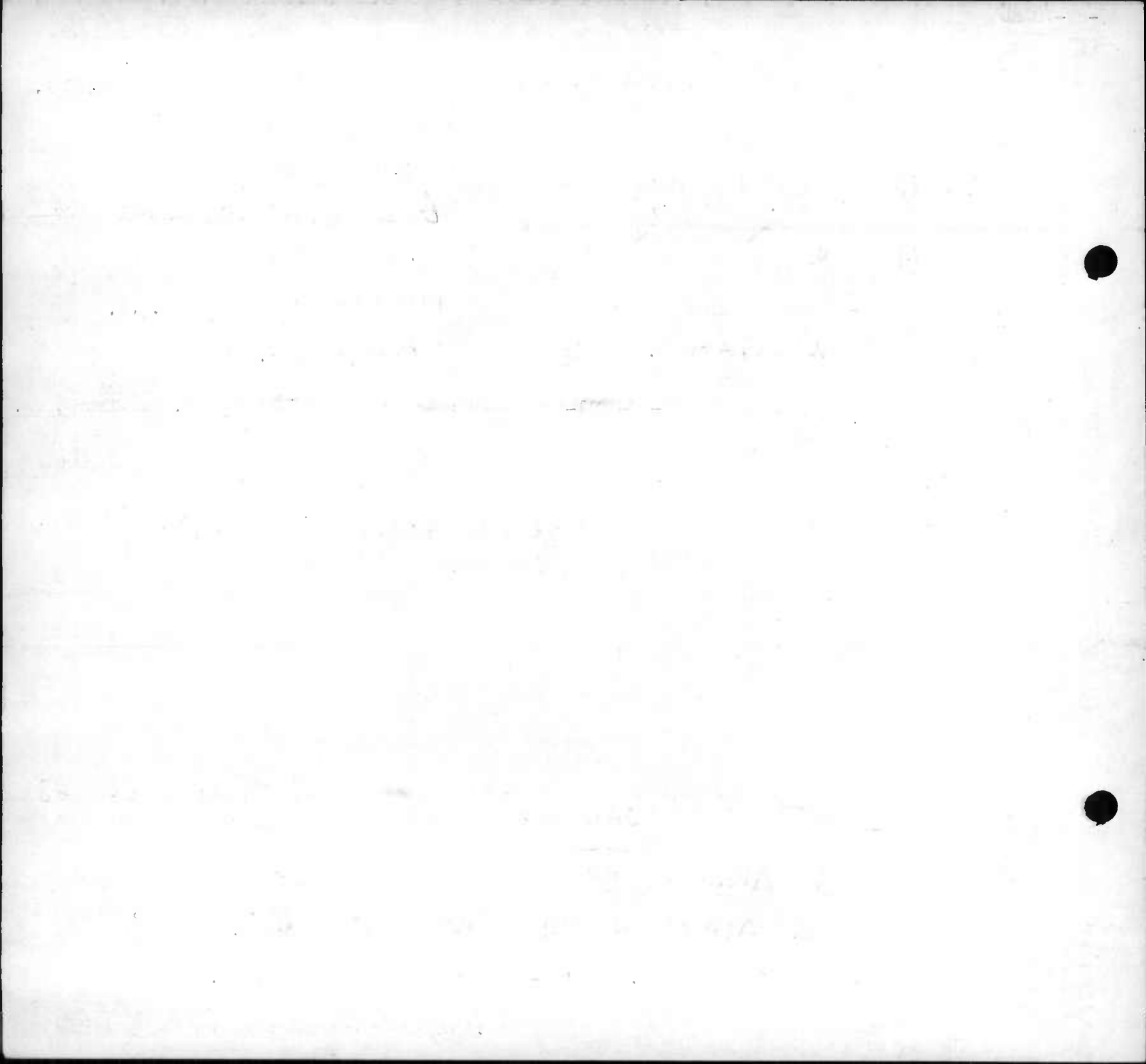
REG. NO. 68- 1074

BIRTH NO.		1. NAME OF DECEASED (Type or Print) RAWLINGS, CLARENCE		2. DATE AND HOUR OF DEATH 2:45 AM, JAN. 20 '68		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 36 FRANKLIN SQUARE HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND. B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 27 N. CAREY ST.			
5. SEX M	6. RACE C Non-W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-2-92	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaiah Rawlings				14. MOTHER'S MAIDEN NAME Mary Smith			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-54-5177		17. INFORMANT SUSIE COMMODORE		ADDRESS Dwings, md.	
18. 436.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 331X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE C.V.A. DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 days	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11 AM, JAN. 5, 1968 to 2:45 AM, JAN. 20, 1968 , that (I) (we) last saw the deceased alive on 2:45 AM, JAN. 20, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Hyung Non Lee				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED JAN. 20, 1968	
23C. PHYSICIAN'S NAME (Type) HYUNG NON LEE, M.D.				23D. ADDRESS 100 N. CALHOUN STR. BALTIMORE, MD.			
24A. BURIAL OR CREMATION, (Specify) REMOVAL		24B. DATE 1-25-68		24C. NAME OF CEMETERY OR CREMATORY MT. Hope Ch. Cem.		24D. LOCATION (City, town, or county) (State) Calvert Co Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1968		25B. NAME OF REGISTRAR R. B. E. F. Dwyer		25C. FUNERAL DIRECTOR Kelson Funeral Home			
				ADDRESS 1348 N. Calhoun St			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

14-625 68-1075		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	68-1075
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) JOHN BRICE HARRISON			2. DATE AND HOUR OF DEATH 1/22/68 6:40 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTO CITY HOSPITALS 4940 Eastern Ave. Baltimore, Maryland #21224			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3602 ELM AV. 21211 007		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-19-88	9. AGE (In years, last birthday) 79	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Shipping Clerk			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME WILLIAM H. Harrison		
14. MOTHER'S MAIDEN NAME ANNIE T. Fairall			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War I 215-10-5911-A		
16. SOCIAL SECURITY NO.			17. INFORMANT BCH: Records 4940 Eastern Ave. Baltimore, Md.		
18. CAUSE OF DEATH 410.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) SEPSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. SEVERE HAECD = multiple Sepsis CVA and old MI			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 420.1 II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-10-67 to JAN 22 1968 , that (I) (we) last saw the deceased alive on JAN 22 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE G. Alarcón MD			23B. DATE SIGNED 1-22-68		23C. PHYSICIAN'S NAME (Type) G. ALARCÓN MD
23D. ADDRESS 4940 Eastern Ave. Baltimore, Maryland BALTO CITY HOSPITAL #21224			24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 1/25/68		24C. NAME OF CEMETERY or CREMATORY St. Mary's - Hampden		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Wm. F. Turner & Son		25C. FUNERAL DIRECTOR Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT 2568

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1076

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-1076

BIRTH NO.		1. NAME OF DECEASED (Type or Print) KATHERINE BOOTH		2. DATE AND HOUR OF DEATH Jan 25, 1968 4:47 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY	
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 310 RIDGE MEDE RD.		F. CITY OR TOWN BALTIMORE		G. STATE MD.	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-13-09	9. AGE (In years last birthday) 58	10. UNDER 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive - Secretary YWCA			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York
13. FATHER'S NAME VINCENT BOOTH			14. MOTHER'S MAIDEN NAME Miriam M. Virgin		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Vincent Booth ADDRESS 11 Hawthorne Rd. Wellesley Hills, Mass.
18. 03601 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE CARDIOVASCULAR Collapse DUE TO, OR AS A CONSEQUENCE OF: (B) 2° SEVERE Brain Damage DUE TO, OR AS A CONSEQUENCE OF: (C) 2° Meningococcal Meningitis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 0570 II					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Kay Ellen Gilmore MD				23B. DATE SIGNED Jan 25, 1968	
23C. PHYSICIAN'S NAME (Type) KAY ELLEN GILMORE				23D. ADDRESS Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 1/27/68		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 26 1968		25B. NAME OF REGISTRAR Robert E. Taylor MD	
25C. FUNERAL DIRECTOR Wm. F. Tietmeyer		25D. ADDRESS Baltimore, Md.			

ACQUA' CANTINE

TSJ 22.0.18

1948

01 00 00

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-630 68-1077		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1077	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) DR. HERSCHEL C. FRIED		2. DATE AND HOUR OF DEATH 1-25-68 1:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		E. STREET AND NUMBER 5702 Bland Avenue #21215			
5. SEX Male	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-5-34	9. AGE (In years last birthday) 33	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOCTOR PROFESSOR		10B. KIND OF BUSINESS OR INDUSTRY TEACHING		11. BIRTHPLACE (State or foreign country) Maryland, BALTIMORE	
13. FATHER'S NAME Jacob Fried		14. MOTHER'S MAIDEN NAME TORA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes or unknown) (If yes, give war or dates of service) AIR FORCE 212-34-2536		16. SOCIAL SECURITY NO.		17. INFORMANT MR. JACOB FRIED, 5702 BLAND AVENUE #21215	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 238.91		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CNS edema (B) CNS tumor (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 237X II 1-24-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on 1-25-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ea Gedosh		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1-25-68	
23C. PHYSICIAN'S NAME (Type) EDGAR A. GEDOSH MD.		23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 1-26-68	24C. NAME OF CEMETERY or CREMATORY RUDOMER VEREIN		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	

Union Memorial Hospital

Male W

10-2-34 33

Missouri 200 Maryland

First floor

John P. ...

1st floor

CNR ...

1-4-38

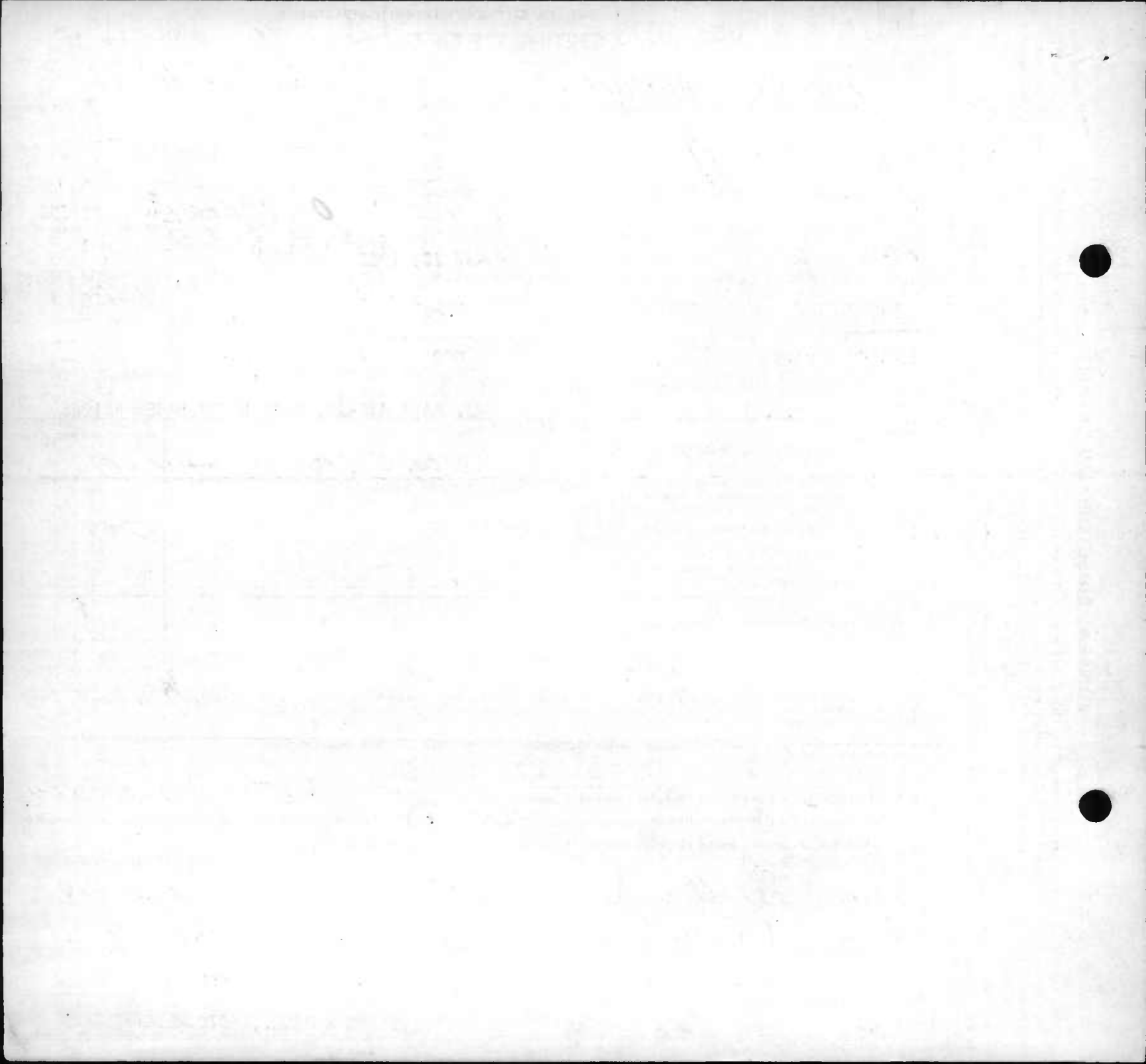
3rd floor

1-4-38

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

A-165-68-1078		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1078	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) HARRY ABRAMS		2. DATE AND HOUR OF DEATH 6:45 AM 1/25/68	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Balto		M.	
FULL NAME OF HOSPITAL OR INSTITUTION 425 Penna Hosp		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 7602 LORRY LANE		#21208			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1894 MAY 22, 1908	9. AGE (In years lost birthday) 73	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROPRIETOR		10B. KIND OF BUSINESS OR INDUSTRY TAXI CABS		11. BIRTHPLACE (State or foreign country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME RALPH ABRAMS		14. MOTHER'S MAIDEN NAME DORA ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. I		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. SARA ABRAMS, 7602 LORRY LANE #21208	
18. 420.1 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ACUTE MI		1 DAY	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) ASCVD DUE TO, OR AS A CONSEQUENCE OF:		YEARS	
(C) _____					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10 19 68 to 1-25 1968 , that (I) (we) last saw the deceased alive on 1-25 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jerome J. Collier MD		23B. DATE SIGNED 1-25-68			
23C. PHYSICIAN'S NAME (Type) Jerome J. Collier MD.		23D. ADDRESS 2217 South Rd Balto-9 MD			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-26-68		24C. NAME OF CEMETERY or CREMATORY BNAI ISRAEL	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JAN 26 1968		25B. NAME OF REGISTRAR Robert E. Taylor, MA	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS			

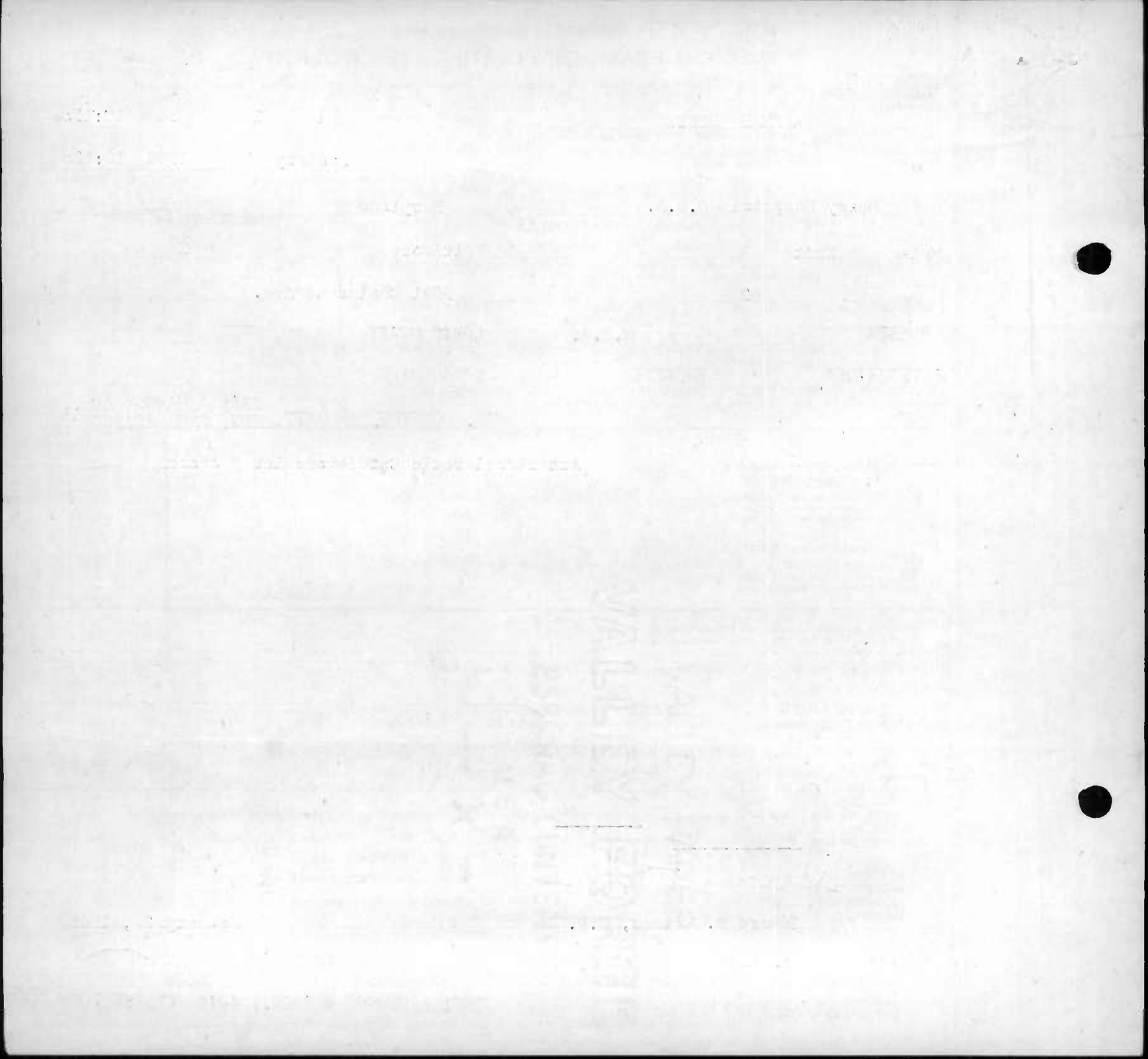


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-1079

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HERMAN HYATT		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year 1 24 68		Hour 10:12a M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 299 Mercy Hospital D.O.A. (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year January 24 1968		Hour 10:12a M.
6. SEX Male		7. RACE White	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 62		10. AGE (In years last birthday) 62		11. BIRTHPLACE (State or foreign country) RUSSIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME LOUIS HYATT		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENTERTAINER
15. MOTHER'S MAIDEN NAME SARAH HARRIS		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO.
18. INFORMANT MRS. DOROTHY SCHWARTZ, APT. 2 B		ADDRESS 2715 A HANSON AVE., #21209		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19. CAUSE OF DEATH 412.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:		
20. DATE OF OPERATION 422.11		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D. DATE SIGNED January 24, 1968				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-26-68		24C. NAME OF CEMETERY or CREMATORY BNAI ISRAEL
24D. LOCATION (City, town, or county) SOUTHERN AVENUE		24E. DATE REC'D BY HEALTH DEPT. JAN 26 1968		24F. NAME OF REGISTRAR R. E. F. Wilson
25A. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		25B. ADDRESS		25C. DATE SIGNED



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

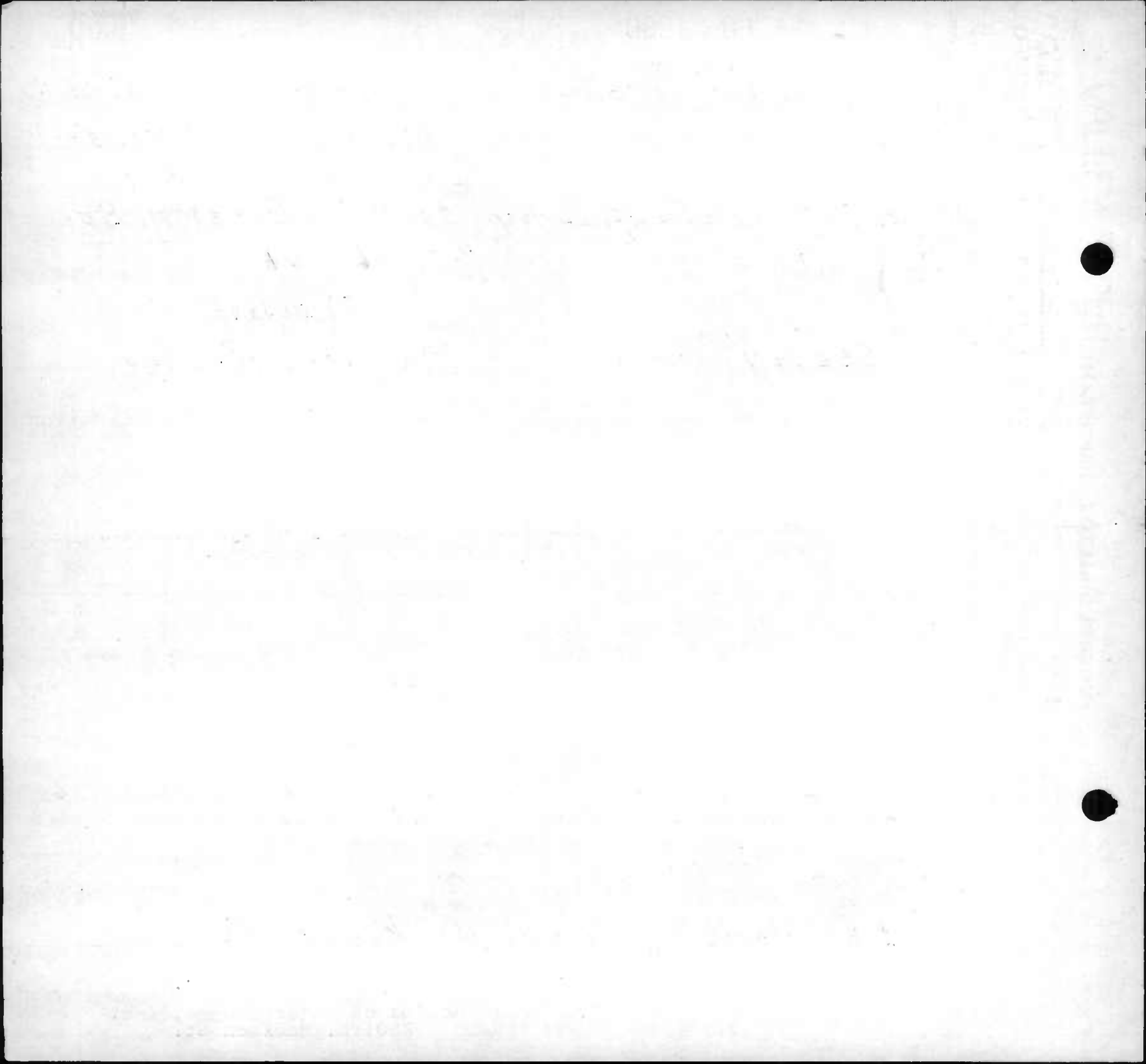
68-1080

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68-1080

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Joseph Porcella</u>		2. DATE AND HOUR OF DEATH <u>1-22-68</u> <u>5:25 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> # <u>2129501</u> B. COUNTY		C. CITY OR TOWN <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>43 South Baltimore General Hosp.</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Globe Detective Agency</u>		8. DATE OF BIRTH <u>7-23-06</u> <u>61</u>	
13. FATHER'S NAME (or Stephen) <u>STEVEN Porcella</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Rooney</u>		9. AGE (In years last birthday) <u>61</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-05-2431</u>		17. INFORMANT <u>Mary Glos Porcella, wife, above</u>	
18. <u>195.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia, bronchopneumonia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>~48 hours</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>190.4 II</u>		(B) Debilitated condition due to squamous cell carcinoma of neck & metastasis DUE TO, OR AS A CONSEQUENCE OF: <u>cell carcinoma of neck & metastasis</u>		(C) _____	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <u>1-20</u> 19 <u>68</u> to <u>1-22</u> 19 <u>68</u> , that (we) lost saw the deceased alive on <u>1-22</u> 19 <u>68</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John Albert Bigbee, M.D.</u>				23B. DATE SIGNED <u>January 23, 1968</u>	
23C. PHYSICIAN'S NAME (Type) <u>John Albert Bigbee, M.D.</u>				23D. ADDRESS <u>1213 Light St.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/26/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>	
24D. LOCATION <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1968</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u>			
25D. ADDRESS <u>2601 E. Madison St.</u>					



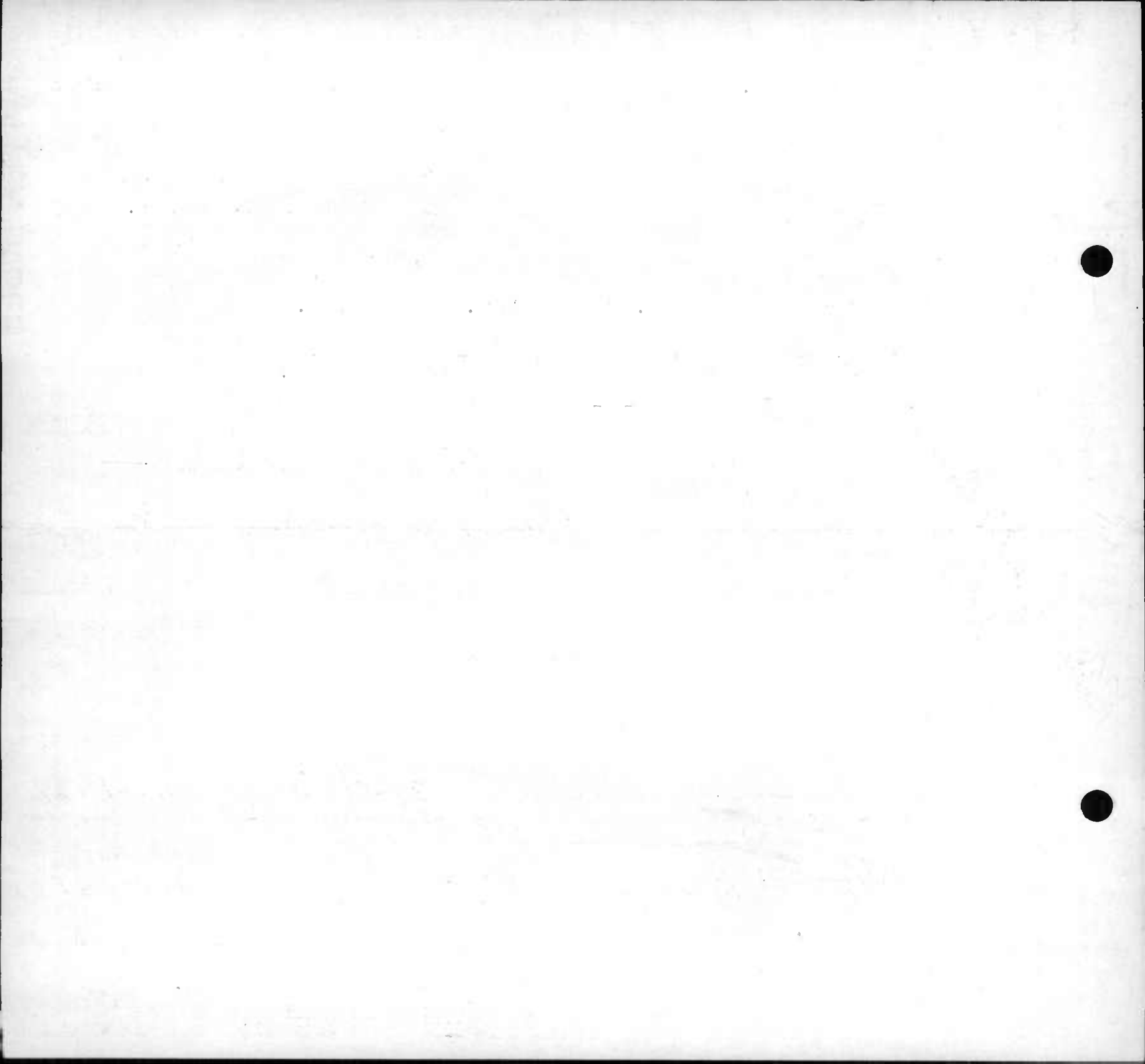
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remarks are embossed or final disposition is made.

68-1081

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-1081

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JOHN B. STEGER		2. DATE AND HOUR OF DEATH January 24, 1968 12:15 a M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 4628 Belair Road Baltimore, Maryland 21213			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER 4628 Belair Road, Baltimore, Md. 21213		
S. SEX male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH May 21, 1896	9. AGE (In years last birthday) 71
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Firefighter		10B. KIND OF BUSINESS OR INDUSTRY Balto. City Fire Dept. Baltimore, Md.		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME William Steger			14. MOTHER'S MAIDEN NAME Martha Magruder		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW 1		16. SOCIAL SECURITY NO. 220-44-0227		17. INFORMANT (nee Thierauf) Mary Ann Steger, wife, above	
18. 41291 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 mos. symptoms		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Heart Disease					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (was did) attended the deceased from 3/15/1968 to 1/24/1968 , that (I) (was did) last saw the deceased alive on 1/13/1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was did) (did not) view the body after death.					
23A. SIGNATURE Albert B Bradley				23B. DATE SIGNED 1/24/68	
23C. PHYSICIAN'S NAME (Type) Dr. Albert Bradley				23D. ADDRESS 4900 Belair Road	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/27/68		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery Baltimore, Md.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. JAN 26 1968			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Schimunek Funeral Home 3331 Brehms Lane #13			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1082

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-1082

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Amos, Edward

2. DATE AND HOUR OF DEATH

1-24-68

3:55 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

34
Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐

NO ☐

E. STREET AND NUMBER

4609 Old Frederick Road

5. SEX

M

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

11/25/87

9. AGE (In years
last birthday)

80

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Auto Salesman

10B. KIND OF BUSINESS OR INDUSTRY

Retired

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Amos, John

14. MOTHER'S MAIDEN NAME

Martha Fahnestock

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

215-01-5428

17. INFORMANT

Admission Sheet

ADDRESS

18. 428X I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, oshtenio, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE CEREBRAL HEMORRHAGE

DUE TO, OR AS A CONSEQUENCE OF:

9 DAYS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) MYOCARDIAL DISEASE

DUE TO, OR AS A CONSEQUENCE OF:

UNKNOWN

(C).....

422.2 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Nat While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from JAN 16 1968 to JAN 24 1968,
that (I) (we) last saw the deceased alive on JAN 24 3AM 1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

SW [Signature]

DEGREE

Attending
Phys. ☐

Med.
Director ☐

Staff
Phys. ☒

23B. DATE SIGNED

JAN 24 '68

23C. PHYSICIAN'S
NAME (Type)

SOO WOONG, HONG

DEGREE

23D. ADDRESS

BON SECOURS HOSPITAL

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1/27/68

24C. NAME OF CEMETERY OR CREMATORY

Louisa Park

24D. LOCATION

(City, town, or county)

(State)

Catonsville, Md

25A. DATE REC'D BY HEALTH DEPT.

JAN 26 1968

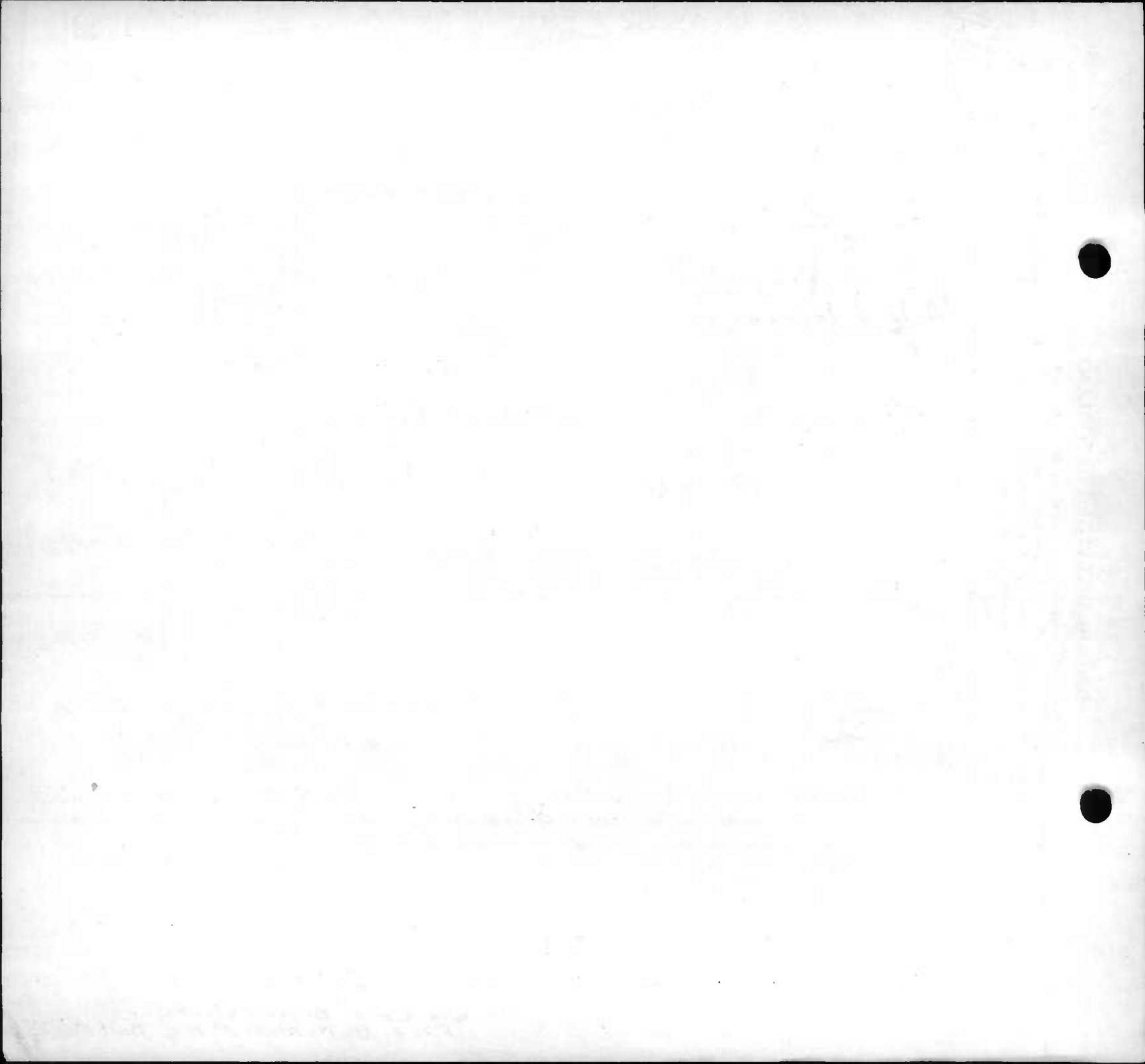
25B. NAME OF REGISTRAR

John E. Johnson

25C. FUNERAL DIRECTOR

Wm. Cook-Brooks West Inc
6212 Balt. Nat. Pike Balt Md 28

ADDRESS



68- 1083

BALTIMORE CITY HEALTH DEPARTMENT

68- 1083

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ingebigt G. Kallevik		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 1 24 68 1:05 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) South Baltimore General Hospital D.O.A.		3. DATE PRONOUNCED DEAD Month Day Year Hour January 24, 1968 1:05 p.m.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Norway B. COUNTY V-61	
9. DATE OF BIRTH 6-30-1946		10. AGE (In years lost birthday) 21	
11. BIRTHPLACE (State or foreign country) Avaldsnes, Norway		12. CITIZEN OF WHAT COUNTRY? Norway	
13. FATHER'S NAME Unknown		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman	
15. MOTHER'S MAIDEN NAME Unknown		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. None		18. INFORMANT Calvert and Redwood St. O. Nielsen 603 Md. Trust Building	

19. CAUSE OF DEATH E 838, 1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Ship	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Port Cuyington		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) Unknown	
22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject injured in ship board acc. when boom broke	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED January 24, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 1/26/1968	
24C. NAME OF CEMETERY OR CREMATORY Moksheim, Norway		24D. LOCATION (City, town, or county) (State) Moksheim, Norway	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc. Balto., Md. 21202 USA		25D. ADDRESS	

9

RECEIVED

NOV 19 1944

U.S. DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WASHINGTON, D.C.

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

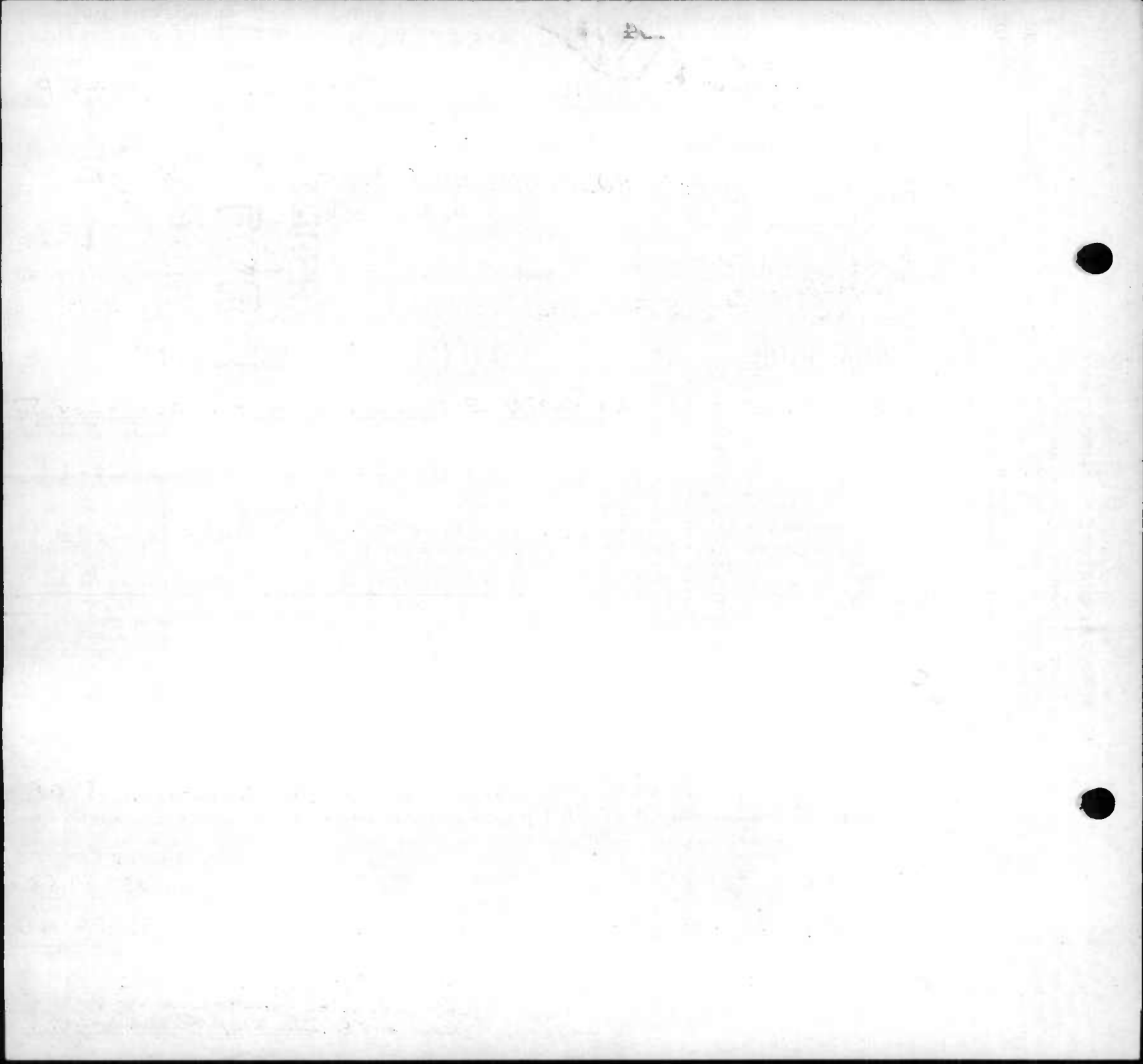
100-100000

100-100000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-400		68-1084		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1084	
BIRTH NO.				1. NAME OF DECEASED <u>LOUIS B. KUHL</u>			
2. DATE AND HOUR OF DEATH <u>JAN. 25, 1968 8:45 P.M.</u>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION <u>36 FRANKLIN SQUARE HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>10-05</u>			
C. CITY OR TOWN <u>BALTIMORE</u>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>419 S. BENTALOU ST.</u>							
5. SEX <u>MALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-7-01</u>	
9. AGE (In years last birthday) <u>66</u>		10. USUAL OCCUPATION (Give kind of work done during last 12 months or if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>RETIRED STEEL MFG.</u>		<u>STEEL MFG.</u>		<u>BALTIMORE, MD.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANK KUHL</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET Schubert</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> <u>NONE</u>				16. SOCIAL SECURITY NO. <u>216-14-0801</u>		17. INFORMANT <u>Evelyn Kuhl</u> ADDRESS <u>419 S. BENTALOU ST.</u>	
18. <u>4220 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>years.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>							
19. DATE OF OPERATION <u>432.1 II</u>				20. AUTOPSY? (Yes or No)			
21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
23. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				24. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
25. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				26. HOW DID INJURY OCCUR?			
27. I certify that (I) (this hospital) attended the deceased from <u>7:45 PM, JAN. 23, 1968</u> to <u>8:45 PM, JAN. 25, 1968</u> , that (I) (we) last saw the deceased alive on <u>8:45 PM, JAN. 25, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
28. SIGNATURE <u>Hyung K. Lee M.D.</u>				29. DATE SIGNED <u>JAN. 25, 1968</u>			
30. PHYSICIAN'S NAME (Type) <u>HYUNG KON LEE, M.D.</u>				31. ADDRESS <u>100 N. CALHOUN STR. BALTIMORE, MD.</u>			
32. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>				33. DATE <u>1-29-68</u>			
34. NAME OF CEMETERY OR CREMATORY <u>LONDON PARK</u>				35. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>			
36. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1968</u>				37. NAME OF REGISTRAR <u>Robert E. Farley</u>			
38. FUNERAL DIRECTOR <u>Geo. L. Schwalb</u>				39. ADDRESS <u>2101 Hudson Ave.</u>			



A-1401

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1085

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-1085

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JOHN APPEL		2. DATE AND HOUR OF DEATH January 23, 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 20-07		5. CITY OR TOWN BALTIMORE-29	
FULL NAME OF HOSPITAL OR INSTITUTION FRANKLIN SQUARE HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1-29-68		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 314 EDGEWOOD ST.		6. SEX M		7. RACE W	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. DATE OF BIRTH 3-5-96		10. AGE (In years last birthday) 71	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME JOHN APPEL		14. MOTHER'S MAIDEN NAME ELIZABETH GINTER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 705-05-6729		17. INFORMANT LILLIE MILLER, 314 EDGEWOOD ST.		ADDRESS	
18. 424.91 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) Pulmonary insufficiency		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years ±	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 421.3 II		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JAN. 22, 1968 to 9:15 PM, JAN. 23, 1968 . that (I) (we) last saw the deceased alive on 9:15 PM, JAN. 23, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Hyung K. Lee M.D.				23B. DATE SIGNED JAN. 23, 1968	
23C. PHYSICIAN'S NAME (Type) HYUNG KON LEE, M.D.				23D. ADDRESS 100 N. CALHOUN ST. BALTIMORE, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-27-68		24C. NAME OF CEMETERY or CREMATORY Loudon Park	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR J. B. Thayer		25D. ADDRESS 1300 Eastern Ave			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1086

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

REG. NO.

68-1086

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Williams, Son

2. DATE AND HOUR OF DEATH

1/11/68

2:10 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

38 UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

md.

C. CITY OR TOWN

BALTO

D. INSIDE CITY LIMITS?

YES ☐

NO ☐

E. STREET AND NUMBER

102 PACA ST.

5. SEX

M

6. RACE

N

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

1896

9. AGE (In years last birthday)

71

If Under 1 Yr. Months: Days: Hours: Min.

If Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. *390.0 I*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

Pulmonary Embolus

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1/2 hr + 1d

(B) DUE TO, OR AS A CONSEQUENCE OF:

Shock, septic Pyelonephritis, acute

3d

(C) CHRONIC

Chronic

200.0 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) *this hospital* attended the deceased from *1/5/68* to *1/11/68* and that (I) (we) last saw the deceased alive on *1/11/68* and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Kurt P. Sligar, MD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1/11/68

23C. PHYSICIAN'S NAME (Type)

KURT P. SLIGAR, MD

23D. ADDRESS

University Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

1-18-68

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

UNIVERSITY MEDICAL SCHOOL

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

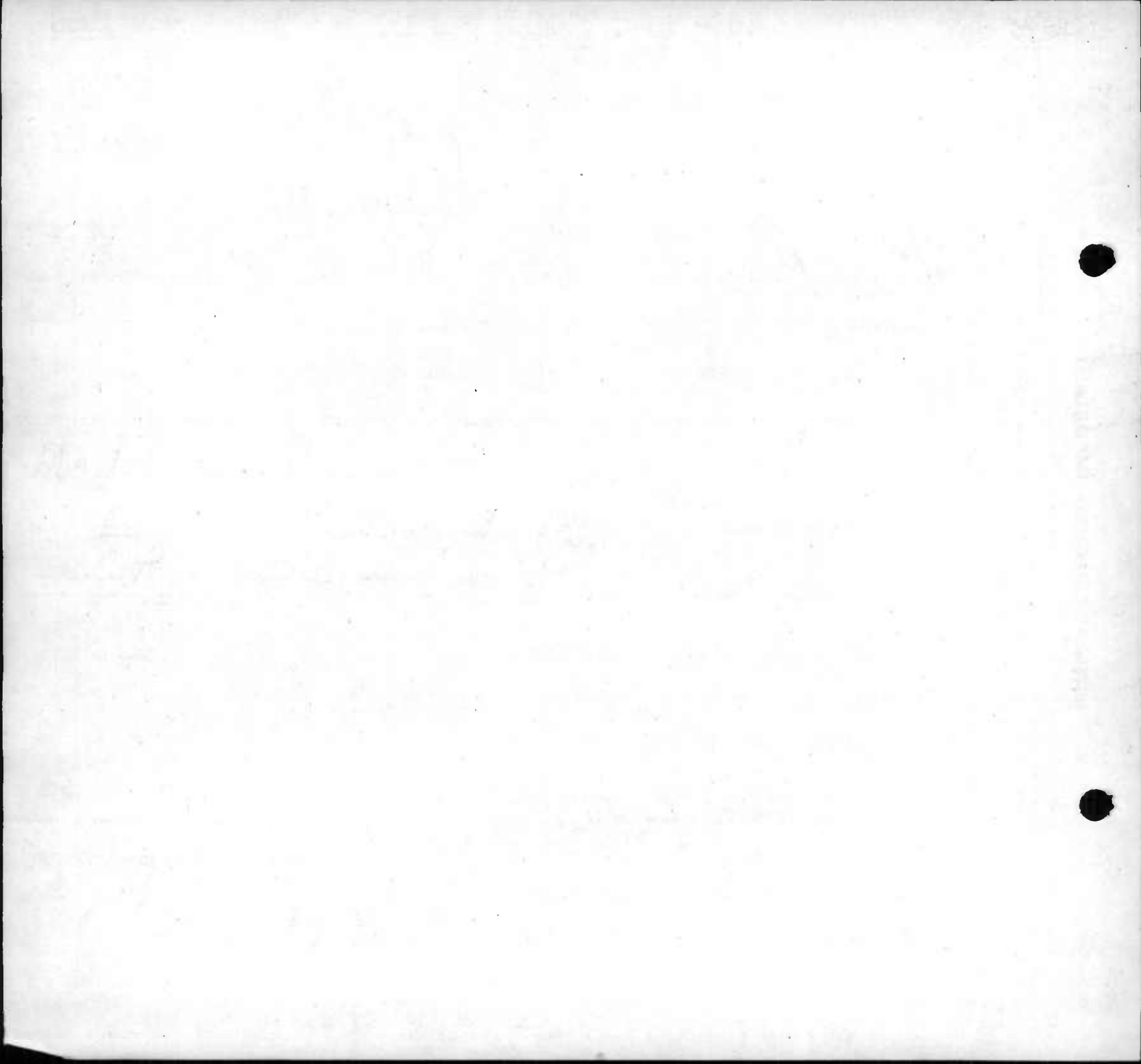
25C. FUNERAL DIRECTOR

ADDRESS

JAN 28 1968

Robert E. Ferguson

HOSPITAL DISPOSAL



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-1087</u>
BIRTH NO. <u>68-1087</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Lucille Bailey</u>		2. DATE AND HOUR OF DEATH <u>1/20/68</u> <u>645 a.m.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>THE JOHNS HOPKINS HOSPITAL</u> <u>BALTIMORE, MD 21205</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>10-02</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>952 N. EDEN STREET</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-25-14</u>	9. AGE (In years last birthday) <u>53</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
13. FATHER'S NAME <u>Edward Bailey</u>		14. MOTHER'S MAIDEN NAME <u>Viola</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Chart,</u>
18. <u>400.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Uremia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>445X II</u>		(B) <u>Malignant Hypertension</u> <u>5 years</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>No</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>1/11</u> <u>19 68</u> to <u>1/20</u> <u>19 68</u> , that (I) (we) last saw the deceased alive on <u>1/20</u> <u>19 68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Dudley D Goulden M.D.</u>				23B. DATE SIGNED <u>1/20/68</u>
23C. PHYSICIAN'S NAME (Type) <u>DUDLEY GOULDEN M.D.</u>		23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>1/28/68</u>	24C. NAME OF CEMETERY or CREMATORY <u>MT Calvary Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>A A County Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 29 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Adolphus Halstead 1206 W North Ave</u>

10/20

B-620

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1088

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 1088

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

BEULAH BROOKS

2. DATE AND HOUR OF DEATH

01 26 68

11:08A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

ST. AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☐NO ☐

E. STREET AND NUMBER

413 CAMBRIA ST 21225

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

06 05 05

9. AGE (In years
last birthday)

62

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF WHAT COUNTRY?

U S A

13. FATHER'S NAME

MILTON

Brooks

14. MOTHER'S MAIDEN NAME

Addie Harper

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT BALTO MD 21229 ADDRESS

ST AGNES HOSP RECORDS WILKENS & CATON

18. 360.21
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

CARDIOVASCULAR COLLAPSE

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) SMALL BOWEL NECROSIS

DUE TO, OR AS A CONSEQUENCE OF:

(C) SMALL BOWEL VOLVULUS

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

Hours

3 DAYS

3 DAYS

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

NONE

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ☒ (this hospital) attended the deceased from 01 23 19 68 to 01 26 19 68,
that ☒ (we) lost saw the deceased alive on 01 26 19 68 and that XX (our) opinion death occurred on the date
and hour and from the causes stated above. X(1) (We) (did) XXXX view the body after death.

23A. SIGNATURE

W. Legner M.D.

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

1/26/68

23C. PHYSICIAN'S
NAME (Type)

23D. ADDRESS

DEGREE

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1/30/68

24C. NAME of CEMETERY or CREMATORY

Glen Haven Cem.

24D. LOCATION

(City, town, or county)

Glen Burnie

AA Co

Md

25A. DATE REC'D BY HEALTH DEPT.

JAN 29 1968

25B. NAME OF REGISTRAR

Robert E. Taniguchi

25C. FUNERAL DIRECTOR

Mc Gilly F.H. 237 Potomac Ave

ADDRESS

21275

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

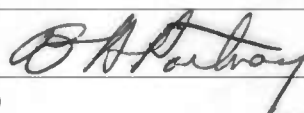
111

111

111

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1089
K-246 BIRTH NO. 68-1089		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) CHARLES E. KESSLER		2. DATE AND HOUR OF DEATH 1-25-68 10²⁰ P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 UNIVERSITY HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 504 E. Gement St.		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 15, 1879	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY Furniture		9. AGE (In years lost birthday) 88
13. FATHER'S NAME George Kessler		14. MOTHER'S MAIDEN NAME Kate Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. Carlton E. Kessler Box 145 Rt 2
CAUSE OF DEATH				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 412.91 ACUTE RENAL FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASPIRATION PNEUMONIA (B) DUE TO, OR AS A CONSEQUENCE OF: A.S.H.D. (C) Middle Cerebral Artery Thrombosis		
MEDICAL CERTIFICATION				
19A. DATE OF OPERATION 420.0 II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 1-18 1968 to 1-25 1968, that (I) (we) last saw the deceased alive on 1-25 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE 		23B. DATE SIGNED 1-25-68		23C. PHYSICIAN'S NAME (Type) UNIVERSITY HOSPITAL
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1 29 68		24C. NAME OF CEMETERY or CREMATORY Glen Haven
24D. LOCATION (City, town, or county) (State) Glen Burnie, A. A. Co. Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968		
25B. NAME OF REGISTRAR Robert E. Fairley		25C. FUNERAL DIRECTOR ADDRESS Mc Cully 130 E. Fort Ave.		

UNIVERSITY HOSPITAL

ACUTE RENAL FAILURE

ASPIRATION PNEUMONIA

ASHO.

Small Central Artery

YES

1-12

1-12

1-12

1-12

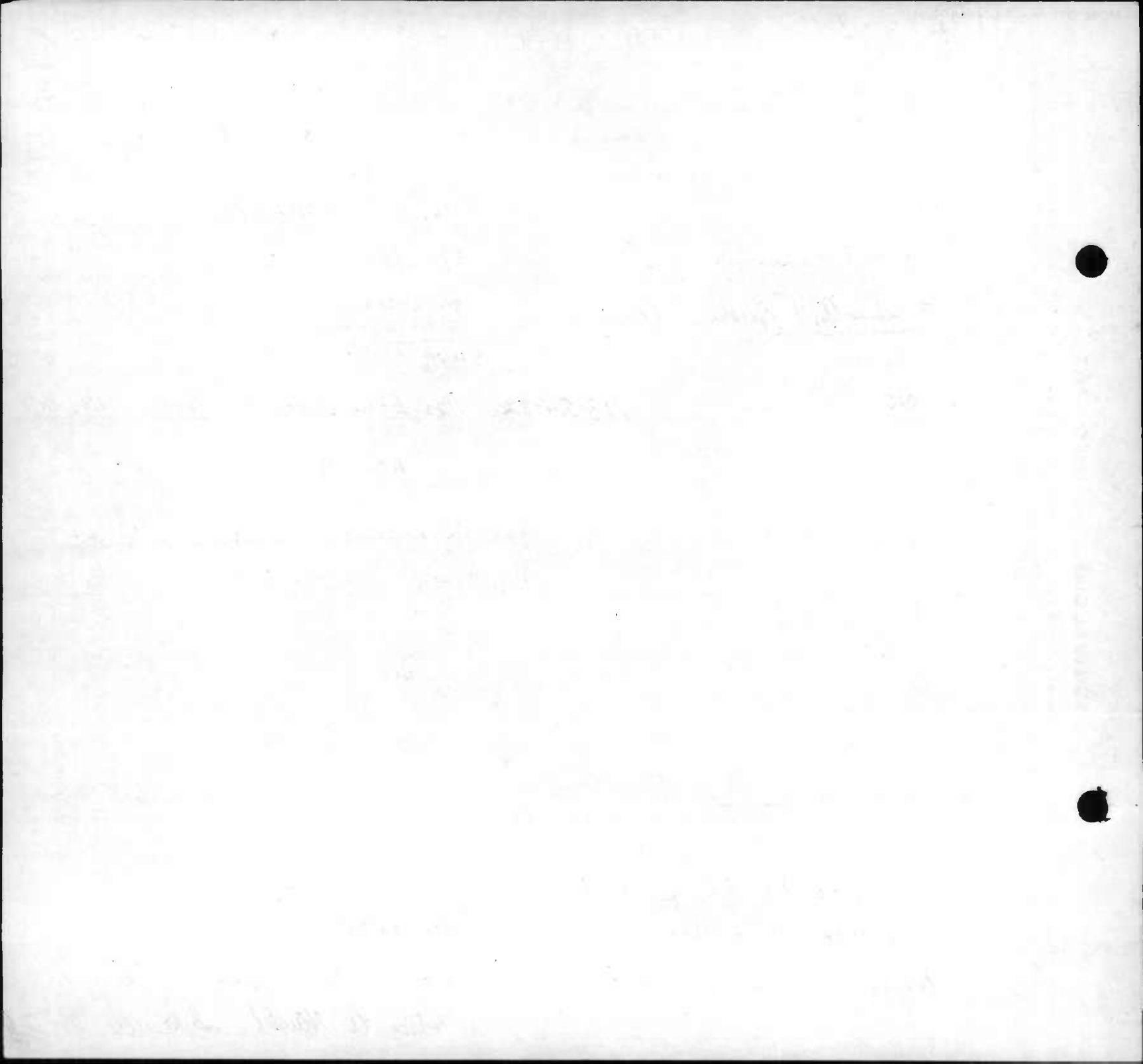
~~Small Central Artery~~

UNIVERSITY HOSPITAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1090	
C-324		68-1090		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		HARVEY CUTSAIL		1/24/68 6:02 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL		A. STATE MD.		B. COUNTY Carroll 56-00	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN SYKESVILLE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER Rt. 4 Box 75			
5. SEX M	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/06/04	9. AGE (In years lost birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fence and Mill operator		10B. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME FRANK		14. MOTHER'S MAIDEN NAME CINDA BELLE HUGHES	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-24-8206		17. INFORMANT Mrs. Effie Cutsail - Sykesville, Md.	
18. 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ASCVD 5+ years		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Possible myocardial infarction 5 days		(B) DUE TO, OR AS A CONSEQUENCE OF:			
Hypotension; renal shutdown 5 days		(C) DUE TO, OR AS A CONSEQUENCE OF:			
420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/19 1968 to 1/24 1968, that (I) (we) lost saw the deceased alive on 1/24 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ronica M. Kluge, M.D.				23B. DATE SIGNED 1/24/68	
23C. PHYSICIAN'S NAME (Type) RONICA M. KLUGE, M.D.				23D. ADDRESS UNIVERSITY HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-27-68		24C. NAME OF CEMETERY OR CREMATORY LAKE View Cemetery	
24D. LOCATION (City, town, or county) (State) Sykesville, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968		25B. NAME OF REGISTRAR Robert E. Jackson	
25C. FUNERAL DIRECTOR Harry W. Haight		25D. ADDRESS Sykesville, Md.			



5.530

68-1091

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-1091

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

RUTH S. SCHMIDT

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month Day Year

1 23 68

Hour

9:46p

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Agnes Hospital D.O.A.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

January 23 1968 9:46 p M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

6. SEX

7. RACE

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

M Female

White

Baltimore

YES ☐NO ☒

9. DATE OF BIRTH

10. AGE (In years
lost birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

AUG. 3, 1920

47

E. STREET AND NUMBER

18 TANGLEWOOD RD.

53-00

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Louisiana

U.S.A.

RODERDEAU SEAY

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

STENOGR.

D.A. OFFICE

NOT KNOWN

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

NO

Walter C. Schmidt 18 Tanglewood Rd

19. 4/2/9

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Arteriosclerotic Cardiovascular Disease

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

422.1

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

2

YES

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

22F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 24, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

Removal

1-24-67

Greenwood Cem.

New Orleans, Louisiana

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JAN 29 1968

Robert E. Taylor

Foley - Lansing L.F.H. - Catonsville, Md.

R-543

68-1092

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-1092

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mary C. Reynolds

2. DATE AND HOUR OF DEATH

7:15 PM 24 Jan 1968

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)Baltimore City Hospital
4940 EASTERN AVENUE
BALTIMORE, MD.4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE
B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

37 S. HIGHLAND AVENUE #21224

5. SEX

FEMALE

6. RACE

W WHITE

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

12-17-75

9. AGE (In years
last birthday)

92

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

AT HOME

11. BIRTHPLACE (State or foreign country)

MARYLAND, BALTIMORE.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

FRANCIS HOLTZMAN

14. MOTHER'S MAIDEN NAME

MARY ANN DUNNIGAN

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT ADDRESS

RECORDS: BALTIMORE CITY HOSPITALS
4940 EASTERN AVE., BALTO., MD. 21224

18.

199.0 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cardiac Arrest

(B) DUE TO, OR AS A CONSEQUENCE OF:

Widespread carcinoma

(C) DUE TO, OR AS A CONSEQUENCE OF:

(Site of Origin Unknown)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

—

MEDICAL CERTIFICATION

199.2 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

Hemorrhage from Urinary bladder.

19A. DATE OF OPERATION

None

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

None

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

None

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

None

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from 23 January 1968 to 24 January 1968,
that (I) last saw the deceased alive on 24 January 1968 and that in (my) opinion death occurred on the date
and hour and from the causes stated above. (I) (did) (did not) view the body after death.

23A. SIGNATURE

John H. Texter

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

24 Jan 68

23C. PHYSICIAN'S
NAME (Type)

John H. Texter

DEGREE

23D. ADDRESS

Baltimore City Hospital, Balt., Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

1-27-68

24C. NAME OF CEMETERY OR CREMATORY

OAK LAWN CEM.

24D. LOCATION (City, town or county)

7125 EASTERN AVE., BALTO. CO., MD.

25A. DATE RECEIVED BY HEALTH DEPT.

JAN 23 1968

25B. NAME OF REGISTRAR

Robert E. Tankersley

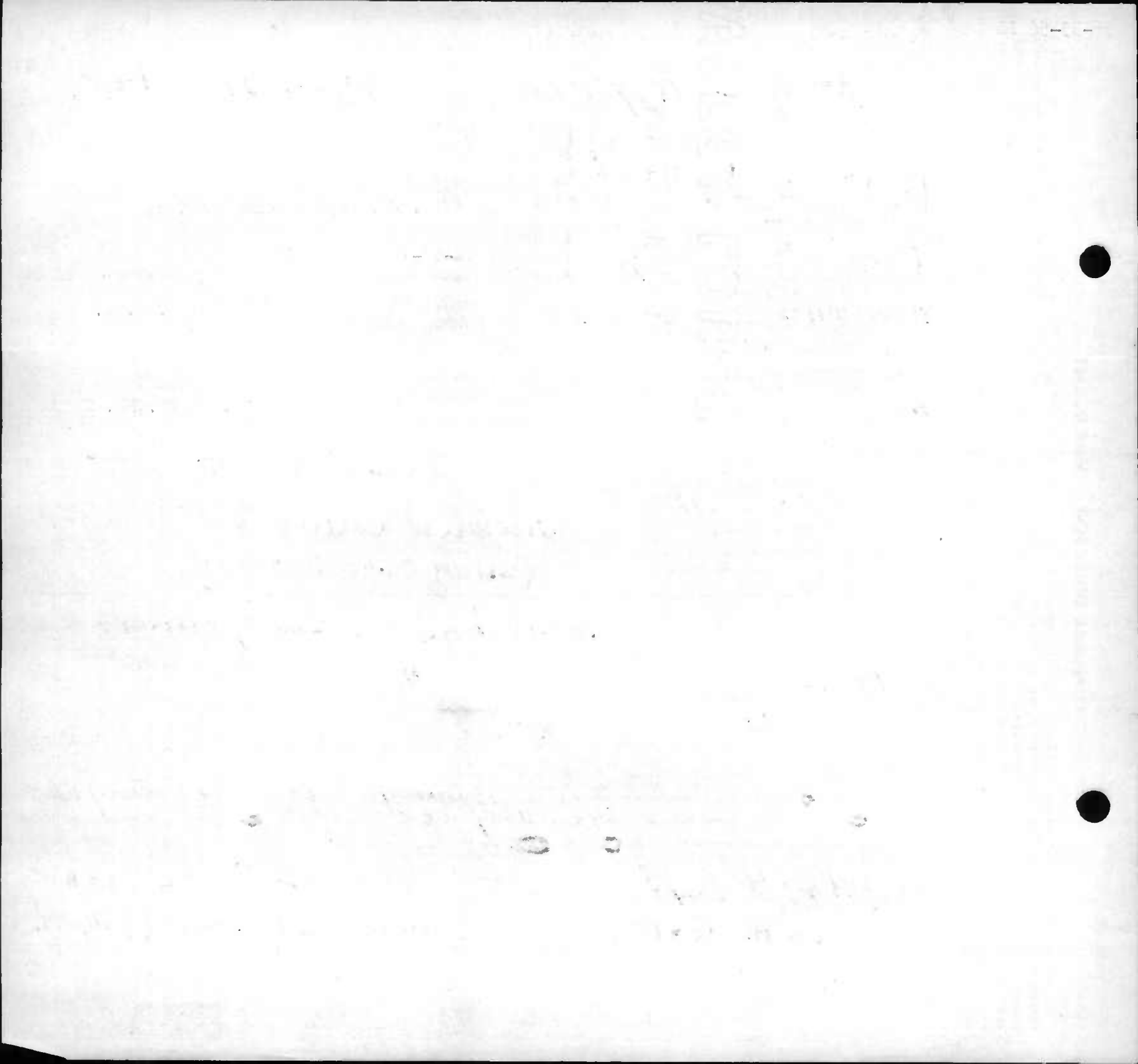
25C. FUNERAL DIRECTOR

Charles F. Gailer 6224 EASTERN AVE.
BALTO., MD.

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1093

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-1093

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ANNA M. BAUERNFEIND

2. DATE AND HOUR OF DEATH

January 23, 1968

8:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

406 S. Clinton St.
Baltimore, 21224, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

406 S. Clinton St. # 21224.

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

Oct. 2, 1892

9. AGE (In years last birthday)

75

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House Work

10B. KIND OF BUSINESS OR INDUSTRY

At Home.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry Bauernfeind

14. MOTHER'S MAIDEN NAME

Margaret Rauh

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

212-22-3151

17. INFORMANT

Marie A. Doughney 2222 Eastern Ave. Balto. 24, Md.

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

Coronary Thrombosis

(B) DUE TO, OR AS A CONSEQUENCE OF:

Hypertension

(C) DUE TO, OR AS A CONSEQUENCE OF:

Arterio-sclerosis

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1943 to Jan 23 1968, that (I) (we) last saw the deceased alive on Jan 8, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Jason H. Gaskel

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

1-24-68

23C. PHYSICIAN'S NAME (Type)

Jason H. Gaskel

23D. ADDRESS

637 S. Conkling St., Balto., 21224, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1-26-68

24C. NAME OF CEMETERY OR CREMATORY

Sacred Heart Cemetery

24D. LOCATION

(City, town, or county)

(State)

7401 German Hill Rd., BaCo., Md

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

901 S. Conkling St. Balto., 21224, Md.

JAN 23 1968

Robert E. Faldut

Charles S. Gaskel

George Thomas

Hypocrite
Catharine Johnson

8 MAR 24

James H. Haskel

Charles J. Haskel

68-1094

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-1094

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) ROBERT JAMES COUGHLIN, Sr.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month January Day 24 Year 1968 Hour M. 	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2042 Deering Avenue		3. DATE PRONOUNCED DEAD Month January Day 24 Year 1968 Hour 1:55 P. M. 	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 25-52	
9. DATE OF BIRTH May 14, 1922		10. AGE (In years lost birthday) 45	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Coughlin		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dock Foreman	
15. MOTHER'S MAIDEN NAME Geraldine Eckweiler		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W II	
17. SOCIAL SECURITY NO. 179-16-4553		18. INFORMANT ADDRESS 21230 Mrs. Catherine M. Coughlin, 2042 Deering Ave.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. E 933 X Gunshot wound of head (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). E 976 X II		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2042 Deering Avenue		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 1-24-68 ? m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot welf	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED January 25, 1968 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-29-1968	
24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968		25B. NAME OF REGISTRAR Charles E. Fairley	
25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229			

2000

• 3

10-10-75

5-632

68-1095

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-1095

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

SHIRLEY SCHWARTZ

2. DATE
OF DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

January 25, 1968

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

66 3611 Gwynn Oak Avenue

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

January 25, 1968

9:35 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

6. SEX

Female

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

August 3rd 1927

10. AGE (In years
last birthday)

40

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

3611 Gwynn Oak Avenue

11. BIRTHPLACE (State or foreign country)

Wye Mills, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Max Schwartz

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

none

14B. KIND OF BUSINESS OR INDUSTRY

none

15. MOTHER'S MAIDEN NAME

Doris Schwartz (nee

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (if yes, give war or dates of service)
no

17. SOCIAL SECURITY NO.

none

18. INFORMANT

ADDRESS

Mr. Max Schwartz 3611 Gwynn Oak, Ave.

19.

412.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

422.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 25, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1-26-68

24C. NAME of CEMETERY or CREMATORY

Shaarei Tfiloh Cem.

24D. LOCATION (City, town, or county) (State)

Windsor Mill, Rd. Balto, Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 29 1968

25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

Sylvan S. Lewis & Son
Memorial Chapel

ADDRESS

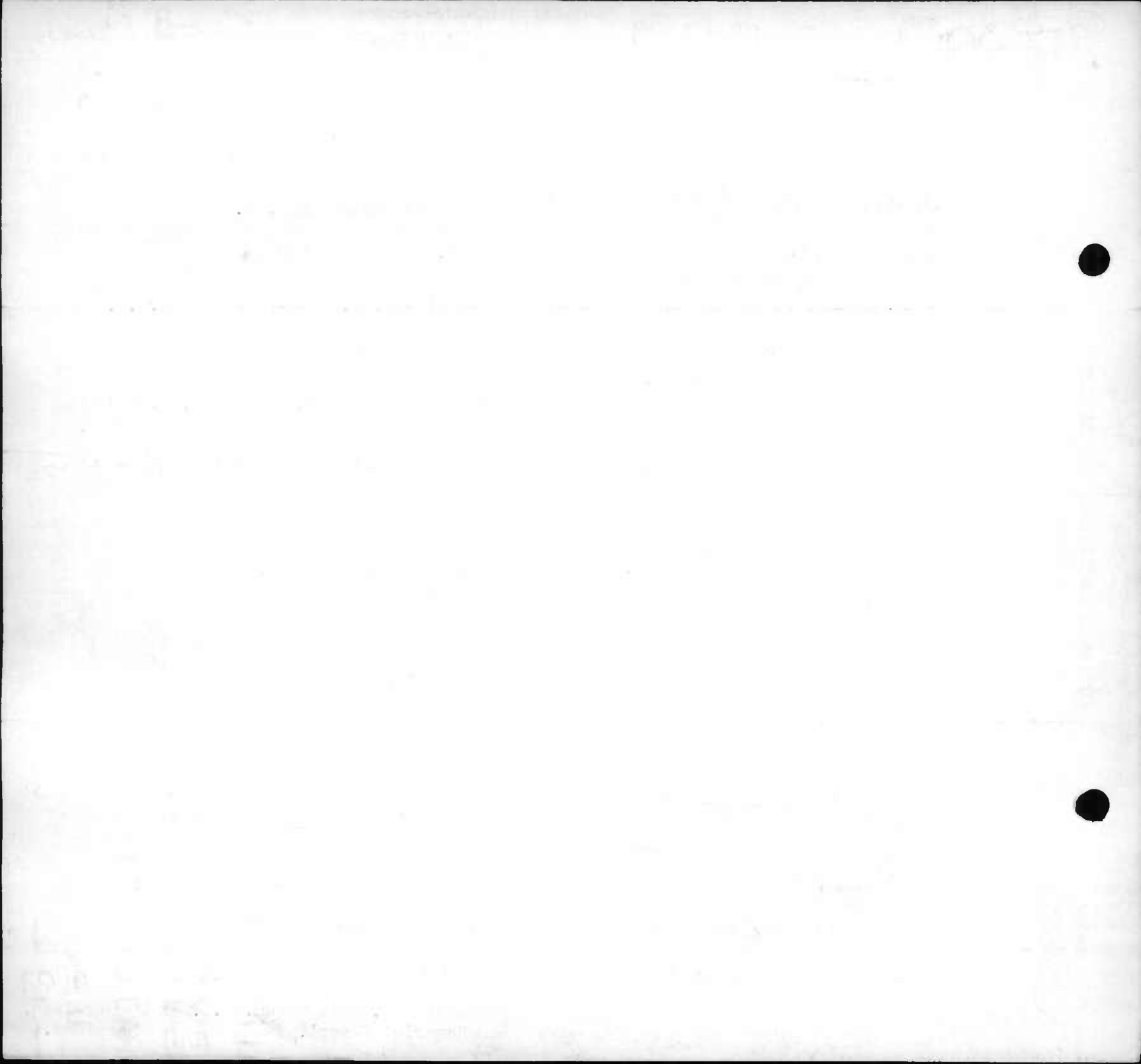
P.O. Box 65 Garrison,
Md.

WALLLEY FORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
68- 1096 CERTIFICATE OF DEATH					Registered No. 68- 1096				
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. _____</p> <p>M.E. CASE NO. _____</p> <p>1. NAME OF DECEASED (Type or Print) FANNIE GOLDSMITH</p> </div> <div> <p>2. DATE AND HOUR OF DEATH 1/25/68 11²⁷ PM M.</p> </div> </div>									
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital of Baltimore</p>					<p>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)</p> <p>A. STATE Maryland B. COUNTY Baltimore</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore</p> <p>D. STREET ADDRESS (If rural, give location) 5921 Western Run, Dr.</p>				
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Sept. 12th 1915	9. AGE (In years last birthday) 52	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Zeisel Ginsberg					14. MOTHER'S MAIDEN NAME ? Mizrach				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. _____		17. INFORMANT ADDRESS Mr Lee Storch 3213 Fallstaff, Rd, 21215				
<p>18. I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p>Ca of Breast, Metastatic</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>					CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs		
<p>170X II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
<p>22. I certify that (I) (this hospital) attended the deceased from 1/25 1968 to 1/25 1968, that (I) (we) last saw the deceased alive on 1/25 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>									
23A. SIGNATURE Kenneth Wetcher M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 1/25/68	
23C. PHYSICIAN'S NAME (Type) KENNETH WETCHER M.D.					23D. ADDRESS Sinai Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-26-68		24C. NAME OF CEMETERY or CREMATORY SHOMREI HADATH CEM.		24D. LOCATION (City, town, or county) (State) ROSEDALE MD.			
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR Robert E. Jackson			25C. FUNERAL DIRECTOR ADDRESS Sylvan S. Lewis & Son. P.O. Box 65 Garrison, Maryland.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-360		68-1097		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1097	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Reda Tudor (REDA O. TUDER)			
2. DATE AND HOUR OF DEATH 1/24/68				6:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				C. CITY OR TOWN Essex		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 26 Warren Road				21221 53-00			
S. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2-22-1921	9. AGE (In years last birthday) 46	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work			10B. KIND OF BUSINESS OR INDUSTRY At Home.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Herman Dietsch				14. MOTHER'S MAIDEN NAME Margaret A. Goetzinger			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 215-14-6679		17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224		
18. 486X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac arrest (B) DUE TO, OR AS A CONSEQUENCE OF: Empyema (C) Pneumonia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min 1 day 5-6 days							
19. 493X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? 27-68			
22. I certify that (I) (this hospital) attended the deceased from 1/24/68 to 1/24/68 and that (I) (we) last saw the deceased alive on 1/24/68 and that in (my) (our) opinion death occurred on the date 1/24/68 and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE David H. Huffman				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/24/68	
23C. PHYSICIAN'S NAME (Type) David H. Huffman				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-27-68		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) (State) 2901 Taylor Ave. Ba. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Charles S. Miller		901 S. Conowing St. Balto., Md.	

(Incl. 10/10/10)

X

2

21

10/10/10

10/10/10

10/10/10

10/10/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1098

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68-1098

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CATHERINE JOYCE KOUWENBERG
KATHERINE KOUWENBERG

2. DATE AND HOUR OF DEATH

1-20-68 8²⁰ P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1/MONTEBELLO STATE HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MD. MONTGOMERY 65-00

C. CITY OR TOWN

SILVER SPRING

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

200 BRYANTS NURSERY RD. SILVER SPRING

5. SEX

F

6. RACE

Cauc.

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

2-22-32

9. AGE (In years
last birthday)

35

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

WASH., D.C.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

BENJAMIN HOBBS

14. MOTHER'S MAIDEN NAME

MABEL ENGLISH

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

579-38-4973

17. INFORMANT

PETER KOUWENBERG

ADDRESS

SAKE 15th 4

18. 011.3 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, oshtenio, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

TUBERCULOUS MENINGITIS

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

5 1/2 months

(B) Pulmonary Tuberculosis, ? active

22 years

(C).....

MEDICAL CERTIFICATION

002.1 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐ Not While
Work At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-16 19 68 to 1-20 19 68,
that (I) (we) last saw the deceased alive on 1-20 19 68 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Michael G. Hayes, M.D.

DEGREE

Attending
Phys. ☐

Med.
Director ☐

Staff
Phys. ☒

23B. DATE SIGNED

1-20-68

23C. PHYSICIAN'S
NAME (Type)

Michael G. Hayes, M.D.

23D. ADDRESS

Montebello State Hosp.

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

JAN 23, 1968

24C. NAME OF CEMETERY OR CREMATORY

FORT LINCOLN CEM

24D. LOCATION

COLMAR MANOR, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

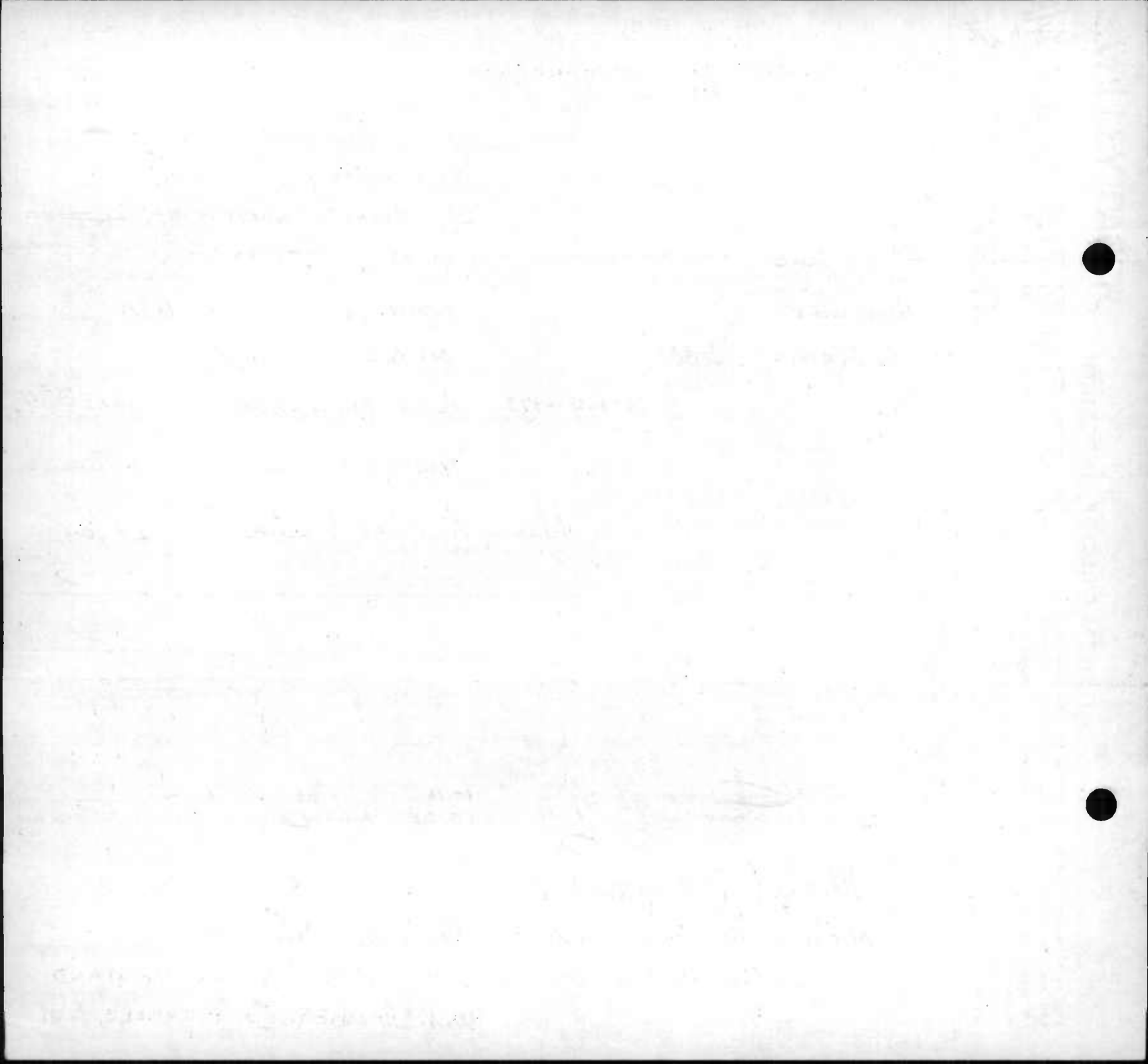
25B. NAME OF REGISTRAR

Albert E. Edwards

25C. FUNERAL DIRECTOR

W.W. CHAMBERS CO. RIVERDALE, MD

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1099

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-1099

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MC CORMICK, MICHAEL P		2. DATE AND HOUR OF DEATH JANUARY 26, 1968 11:15A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY Balto		5. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTIMORE, MD 21229		C. STREET AND NUMBER 4402 SCOTIA RD. 21227		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6. SEX MALE	7. RACE WHITE	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH 7/2/50	10. AGE (In years lost time) 17	11. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		13. KIND OF BUSINESS OR INDUSTRY		14. BIRTHPLACE (State or foreign country) MARYLAND	
15. FATHER'S NAME JOSEPH		16. MOTHER'S MAIDEN NAME LYDA DAVID		17. CITIZEN OF WHAT COUNTRY? U.S.A.	
18. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		19. SOCIAL SECURITY NO.		20. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 036.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		22. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF Meningococcal (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
24. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 057.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		25. DATE OF OPERATION 2		26. CONDITION FOR WHICH OPERATION WAS PERFORMED	
27. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
30. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		31. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		32. HOW DID INJURY OCCUR?	
33. I certify that (I) (this hospital) attended the deceased from JANUARY 25 19 68 to JANUARY 26 19 68 , that (I) (we) last saw the deceased alive on JANUARY 26 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
34. SIGNATURE Dr. H. Campbell, MD		35. DATE SIGNED JAN. 26, 1968		36. ATTENDING Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
37. PHYSICIAN'S NAME (Type) DR. H. CAMPBELL, MD		38. ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE.			
39. BURIAL CREMATION, REMOVAL (Specify) Burial	40. DATE 1/29/68	41. NAME OF CEMETERY OR CREMATORY Glen Haven Cem		42. LOCATION (City, town, or county) (State) Glen Burnie AACo Md	
43. DATE REC'D BY HEALTH DEPT. JAN 29 1968		44. NAME OF REGISTRAR McGulley F.H.		45. FUNERAL DIRECTOR ADDRESS 237 Fatigue Ave	

ADJUTANT GENERAL

ADJUTANT GENERAL

ADJUTANT GENERAL

ADJUTANT GENERAL

ADJUTANT GENERAL

ADJUTANT GENERAL

ADJUTANT GENERAL

ADJUTANT GENERAL

ADJUTANT GENERAL

ADJUTANT GENERAL

ADJUTANT GENERAL

ADJUTANT GENERAL

ADJUTANT GENERAL

ADJUTANT GENERAL

ADJUTANT GENERAL

ADJUTANT GENERAL

ADJUTANT GENERAL

ADJUTANT GENERAL

ADJUTANT GENERAL

ADJUTANT GENERAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 68-1100
1. NAME OF DECEASED (Type or Print) STEELE, George E.		2. DATE AND HOUR OF DEATH 23 JANUARY 1968		7:30 P M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE PENNSYLVANIA B. COUNTY CHESTER		
FULL NAME OF HOSPITAL OR INSTITUTION 23 VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218		C. CITY OR TOWN OXFORD		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX MALE		6. RACE CAUCASION		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY FURNITURE		8. DATE OF BIRTH 9-14-18
13. FATHER'S NAME GEORGE E. STEELE		14. MOTHER'S MAIDEN NAME MARGARET PHILLIPS		9. AGE (In years lost birthday) 49
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. 12-8-42 TO 10-5-45		11. BIRTHPLACE (State or foreign country) OXFORD, PENNSYLVANIA
17. INFORMANT HOSPITAL RECORDS		ADDRESS 3900 LOCH RAVEN BLVD., BALTO., MD 21218		
18. 157-9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Carcinomatous Anaites DUE TO, OR AS A CONSEQUENCE OF: (B) Peritoneal Metastatic DUE TO, OR AS A CONSEQUENCE OF: (C) Gastric Carcionoma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Months 2 Months 2 Months		
19. DATE OF OPERATION 15 IX		20. AUTOPSY? (Yes or No) Yes		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?				
22. I certify that we (this hospital) attended the deceased from 2 JANUARY 19 68 to 23 JANUARY 19 68 , that we last saw the deceased alive on 23 JANUARY 19 68 and that we (our) opinion death occurred on the date and hour and from the causes stated above. we (We) (did) not view the body after death.				
23A. SIGNATURE <i>Gordon F. Murray M.D.</i>		23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) GORDON F. MURRAY		23D. ADDRESS 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-27-68		24C. NAME of CEMETERY or CREMATORY Oxford Cemetery
24D. LOCATION (City, town, or county) (State) Oxford, Penna.		25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968		
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Wm. E. Johnson, 8521 Loch Raven Blvd. 21204		

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

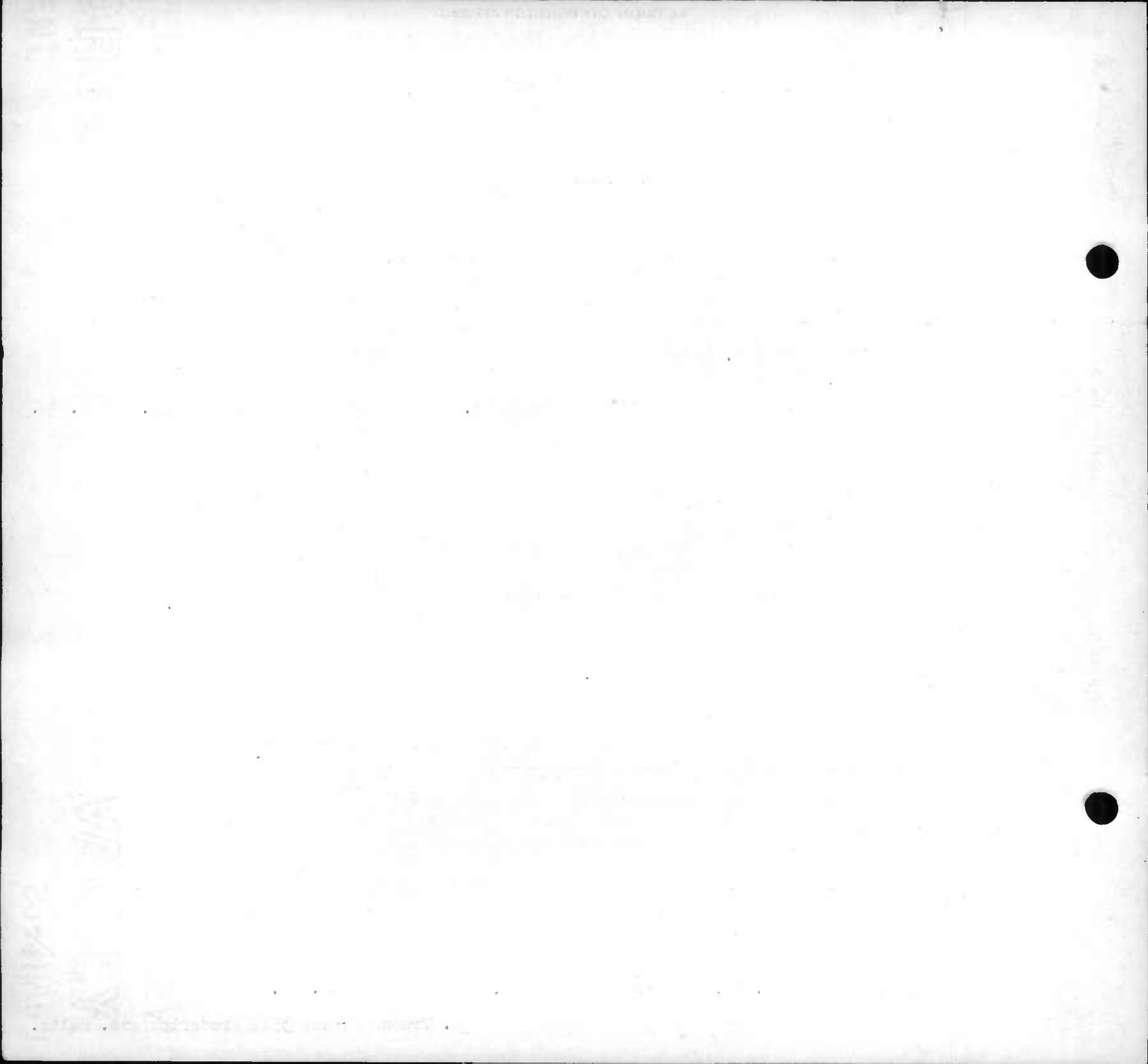
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1101

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-1101

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MARGARET E. HESS (Corinne)		2. DATE AND HOUR OF DEATH 24th January 1968 6-10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 109 OAKLEY VILLAGE		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL OF MARYLAND		E. STREET AND NUMBER 109 OAKLEY VILLAGE		F. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-2-14	9. AGE (In years lost birthday) 53 years	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Charles E. Merson		14. MOTHER'S MAIDEN NAME Naomi Watts	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-03-3479		17. INFORMANT Mr. Gordon Germuth 1736 Winans Ave. Balto. Md.	
18. 174X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 170X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE METASTATIC C. BREAST. DUE TO, OR AS A CONSEQUENCE OF: ME (B) METASTATIC C. BREAST. DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19A. DATE OF OPERATION 1-23-1968		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED METASTATIC C. BREAST.		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-6-68 19 to 1-24-1968 , that (I) (we) last saw the deceased alive on 1/24/1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE T. K. SATYANRITHAN		23B. DATE SIGNED 1-24-1968		23C. PHYSICIAN'S NAME (Type) T. K. SATYANRITHAN	
23D. ADDRESS LUTHERAN HOSPITAL OF MARYLAND 730 ASX Garden St BALTIMORE MD.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE Jan. 27, 1968		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE RECEIVED BY HEALTH DEPT. JAN 25 1968		25B. NAME OF REGISTRAR Robert E. Tarkenton		25C. FUNERAL DIRECTOR G. Truman Schwab 3512 Frederick Ave. Balto.	

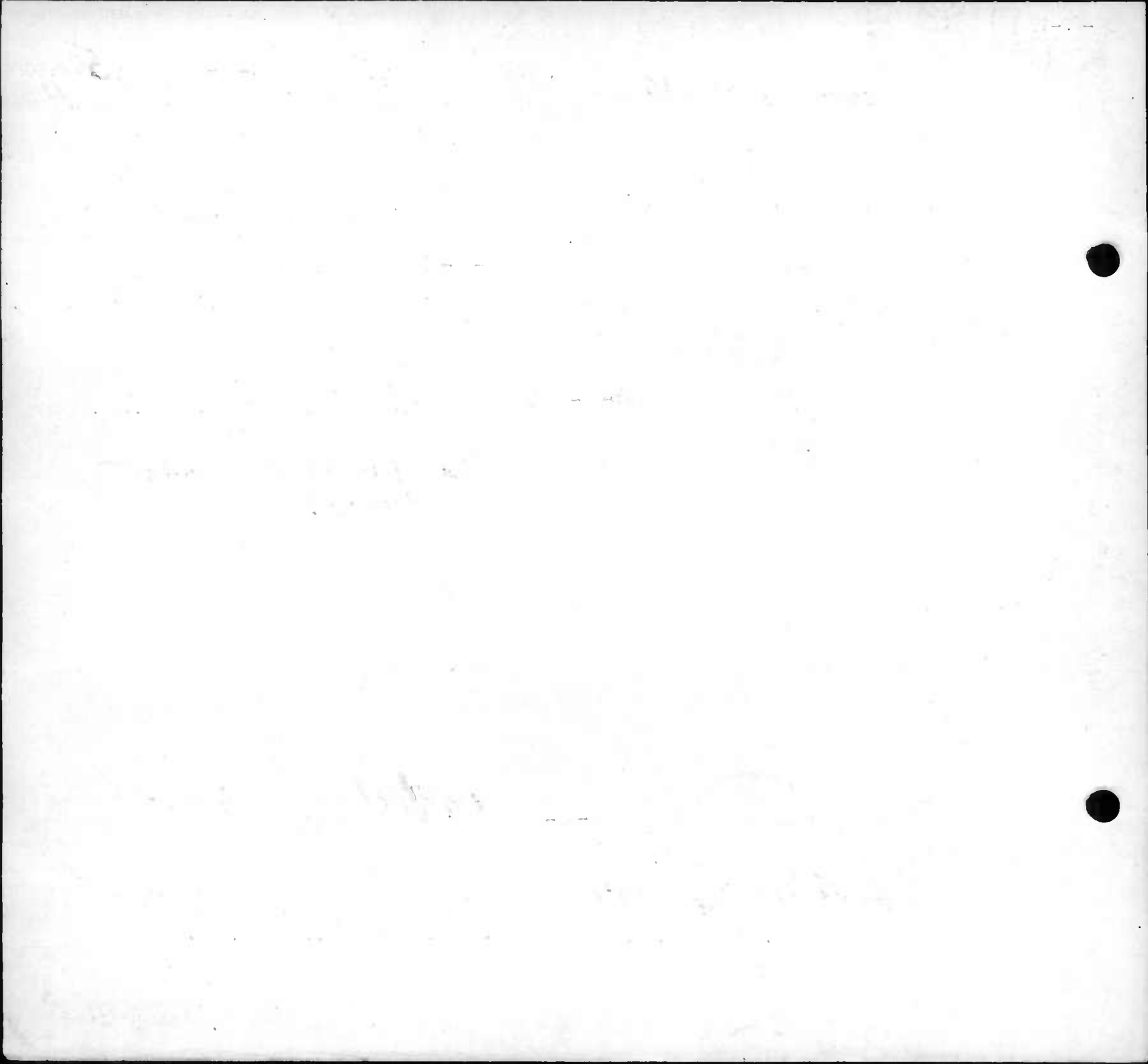


32-60-19 LB

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-216		68-1102		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1102	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Gasper, John GOSPER, JOHN (GOSTOMSKI)			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH 1/23/68 9:50 PM			
FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY			
5. SEX MALE				6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10B. KIND OF BUSINESS OR INDUSTRY Furniture Mfg.		9. AGE (In years last birthday) 84	
13. FATHER'S NAME John Gostomski				14. MOTHER'S MAIDEN NAME Mary (ZIEMBA)		11. BIRTHPLACE (State or foreign country) POLAND	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 219-03-2720A		12. CITIZEN OF WHAT COUNTRY? USA	
17. INFORMANT ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE, BALTO., MD. 21224				18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma - bladder & Prostate ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 199.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 1-23-68 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 12/21/67 19 to 1/23/68 19, that (I) (we) last saw the deceased alive on 1-23-68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE Robert N. Hill M.D. 23B. DATE SIGNED 1/23/68 23C. PHYSICIAN'S NAME (Type) ROBERT N. HILL, M. D. 23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVE., BALTO., MD. #21224 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 1-27-68 24C. NAME OF CEMETERY OR CREMATORY ST. Stanislaus Cemetery 24D. LOCATION (City, town, or county) (State) Baltimore, Md. 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968 25B. NAME OF REGISTRAR Robert E. Fairbank 25C. FUNERAL DIRECTOR ADDRESS Philly E. Crach 1211 Chesaco Ave.			

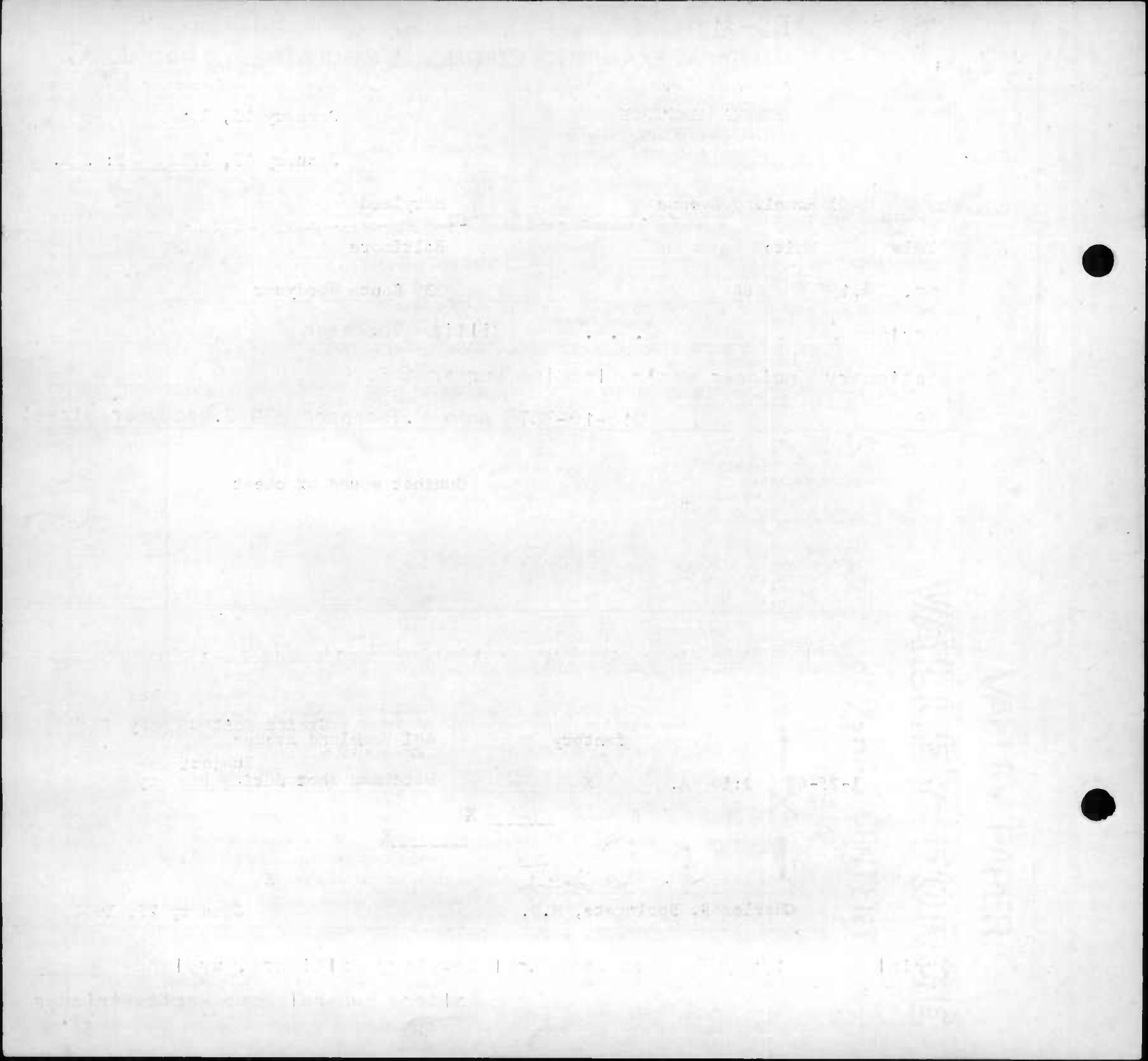


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-1103

BIRTH NO.

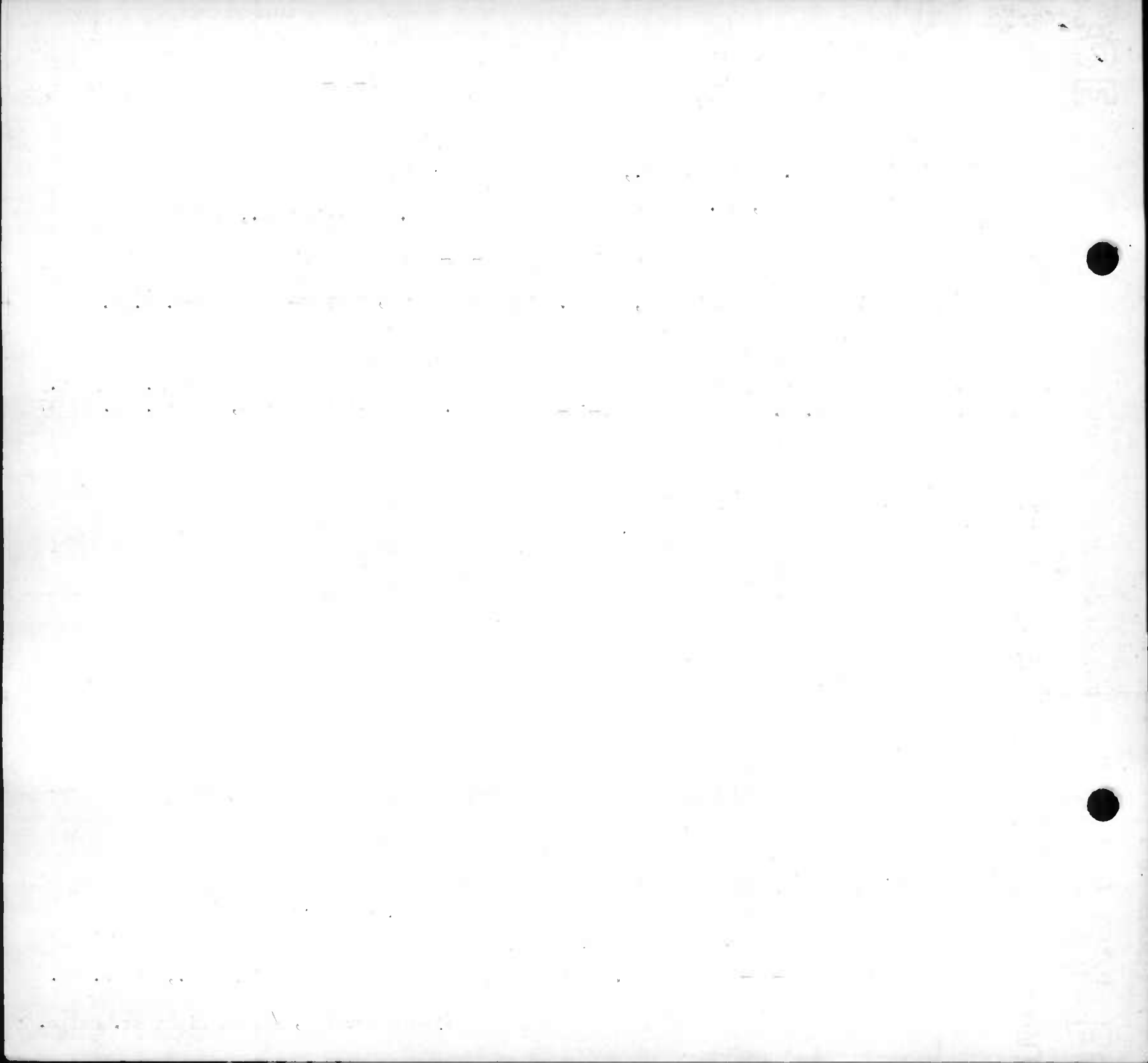
1. NAME OF DECEASED (Type or Print) ROBERT THOMPSON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> January 25, 1968		3. DATE PRONOUNCED DEAD Month Day Year Hour January 25, 1968 3:40 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 401 Homeland Avenue		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 19-03		6. SEX Male 7. RACE White 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Apr. 29, 1903		10. AGE (In years last birthday) 64		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Thompson		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer Men's Clothing	
15. MOTHER'S MAIDEN NAME Margaret Fox		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 218-10-3078	
18. INFORMANT Anna M. Thompson		19. CAUSE OF DEATH E 965 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshot wound of chest DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input checked="" type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) factory		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Greiff Suit Company 401 Homeland Avenue	
22D. TIME OF INJURY (APPROX.) 1-25-68 3:10 A.M.		22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject was a Watchman shot during robbery	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED January 25, 1968					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/29/68		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery Baltimore, Maryland	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968		25B. NAME OF REGISTRAR P. E. Farley	
25C. FUNERAL DIRECTOR Walters Funeral Home		25D. ADDRESS Pratt & Stricker Sts.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 68-1104	
BIRTH NO. D-255				68-1104			
1. NAME OF DECEASED (Type or Print) BERNARD DEGNAN				2. DATE AND HOUR OF DEATH 1-26-68 11:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2220 W. Christian St., Baltimore, Md. 21223				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2220 W. Christian St., 21223			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-11-1892	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Fireman, Balto. City		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Degnan				14. MOTHER'S MAIDEN NAME Mary Kane			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. W. W. 11 217-26-3541		17. INFORMANT Mrs. Catherine Kukleris, Balto. Md. 21237			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.9 I CHRONIC CARDIO-VASCULAR DISEASE 16 months				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 422.1 II				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic Cardio-Vascular Disease 16 months (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 422.1 II							
19A. DATE OF OPERATION 0 NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ✓		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 2, 1966 to Jan 26, 1968 , that (I) (we) last saw the deceased alive on Jan 25, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Frank N. Ogden, M.D.				23B. DATE SIGNED Jan. 27, 1968		23C. PHYSICIAN'S NAME (Type) FRANK N. OGDEN, M.D.	
23D. ADDRESS 2701 N. Calvert St. - Balto. Md.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-29-68		24C. NAME OF CEMETERY or CREMATORY Balto. National Cemetery		24D. LOCATION (City, town, or county) (State) 5501 Frederick Ave., Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR ADDRESS Flynn & Fleming, 1422 Light St. Balto. Md			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

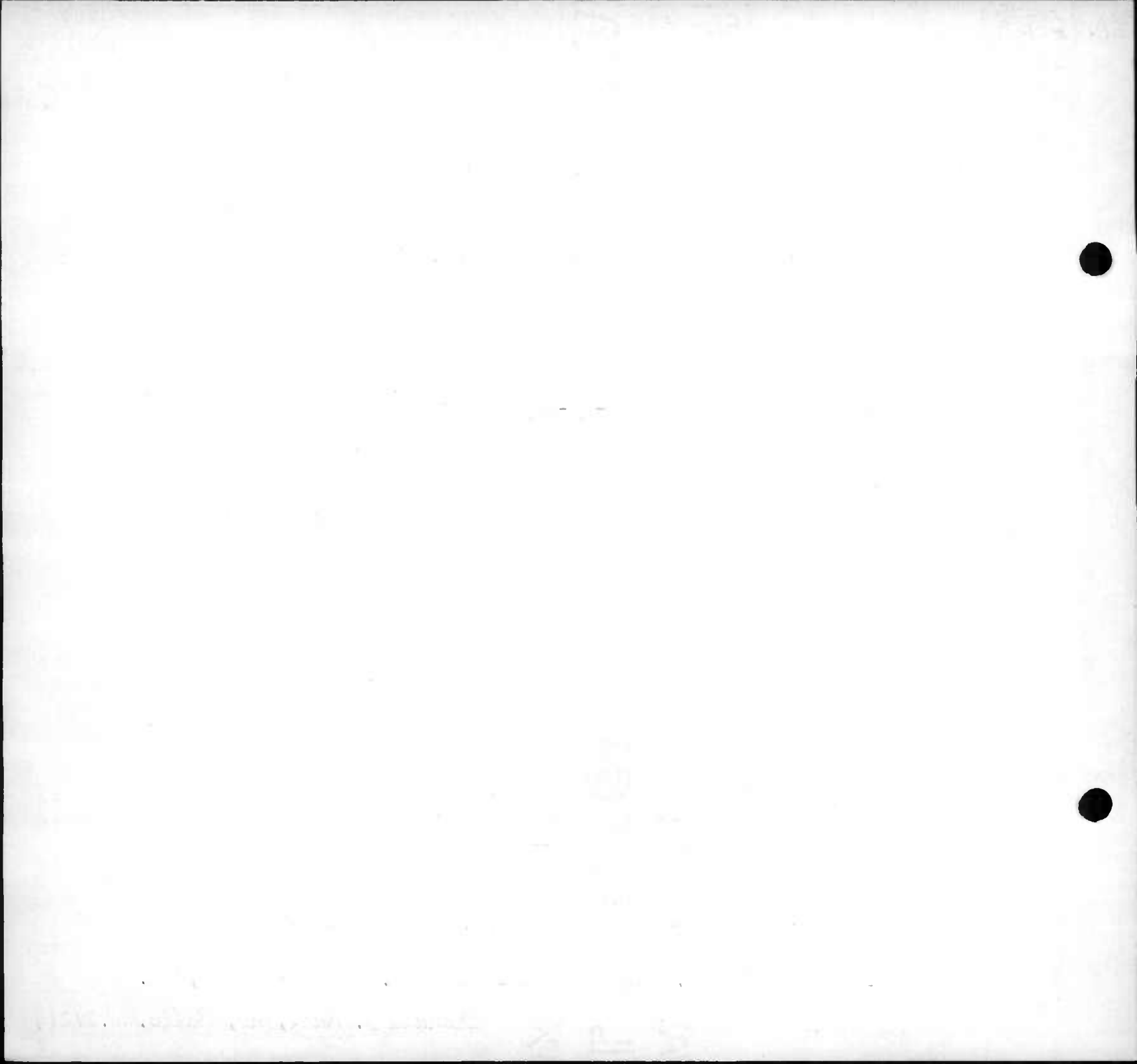
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
68- 1105		CERTIFICATE OF DEATH		68- 1105	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) BOEHM, CLARA J.			2. DATE AND HOUR OF DEATH 1-25-95^{PM} 1968.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 44 The Union Memorial Hospital			A. STATE Maryland B. COUNTY		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 2700 Christopher Ave.		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 5-13-1882	9. AGE (In years last birthday) 85	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	
13. FATHER'S NAME Frank VON DE AUE			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Rudolph Boehm
					ADDRESS (Same)
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute M. I. (posterior)			INTERVAL BETWEEN ONSET AND DEATH Dr. Yen		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Aspirated broncho-pneumonia					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 420.1 II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-25-6 1968 to 1-25 1968, that (I) (we) last saw the deceased alive on 1-25 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Darwish M. Nazzari				23B. DATE SIGNED 1/26/68.	
23C. PHYSICIAN'S NAME (Type) Darwish M. Nazzari				23D. ADDRESS The Union Memorial Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/29/68.		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 23 1968		25B. NAME OF REGISTRAR Robert E. Fairbanks		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	

(Route No. 1, Section 1)
-advised by
Bureau

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				68- 1106	
BIRTH NO.				68- 1106	
M.E. CASE NO.				Registered No.	
1. NAME OF DECEASED (Type or Print) ELSIE P. MILLER			2. DATE AND HOUR OF DEATH Jan. 25, 1968 6:30 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 49 North Charles Gen. Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 26-02 D. STREET ADDRESS (If rural, give location) 5307 SIPPLE AVE. 21206		
5. SEX F.	6. RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 3/7/1884	9. AGE (In years last birthday) 83	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Minutes
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME MILLARD STEFFY			14. MOTHER'S MAIDEN NAME Ann Brothers		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-05-0073	17. INFORMANT ADDRESS Robert Roubenoff 4. 21 N. Charles Gen. Hosp.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.9 I Bronchopneumonia Old myocardial infarct			INTERVAL BETWEEN ONSET AND DEATH		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 420.1 II					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from Jan 20, 1968 to Jan 25, 1968 , that (I) (we) last saw the deceased alive on Jan 25, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert Roubenoff			23B. DATE SIGNED 1/25/1968		
23C. PHYSICIAN'S NAME (Type) Juri Hinnu			23D. ADDRESS M.D. 5002 FRANKFORD AVE 21206		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 1/29/68	24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cem.	24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968		25B. NAME OF REGISTRAR Robert J. Ruck, Inc.	25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc., Balto. Md. 21214		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1107

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-1107

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Frances F. Chenoweth

2. DATE AND HOUR OF DEATH

1-26-68

9:15 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 2913 Fleetwood Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

2913 Fleetwood Ave.

5. SEX

Female

6. RACE

Caucasian

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

Nov. 2, 1887.

9. AGE (In years
last birthday)

80

If Under 1 Yr.
Months: Days

If Under 24 Hrs.
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

George H. Cameron

14. MOTHER'S MAIDEN NAME

Mary Shunk

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

216-52-0782J1

17. INFORMANT

Mrs. Thelma Williams

ADDRESS

(Same)

18. 4/2/91

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Coronary arteriosclerosis

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

2 years

MEDICAL CERTIFICATION

420.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1965 to Jan 26, 1968,
that (I) (we) last saw the deceased alive on Jan 24, 1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Ronald Jandorf

Attending
Phys. ☒

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

1-26-68

23C. PHYSICIAN'S
NAME (Type)

R. Donald Jandorf

23D. ADDRESS

6077 Harford Road

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1/29/68.

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 29 1968

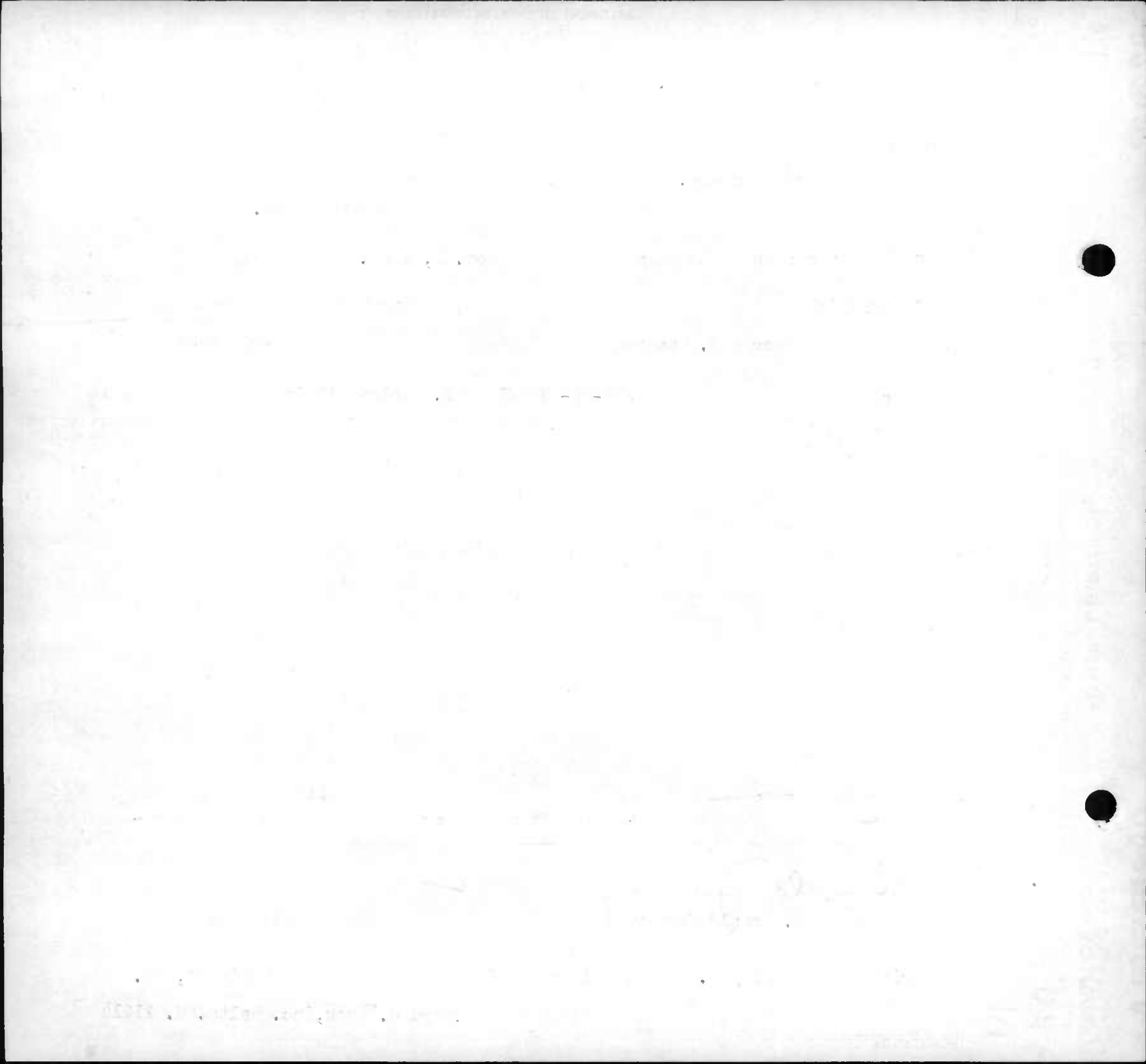
25B. NAME OF REGISTRAR

Robert E. Jandorf

25C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc. Balto. Md. 21214

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

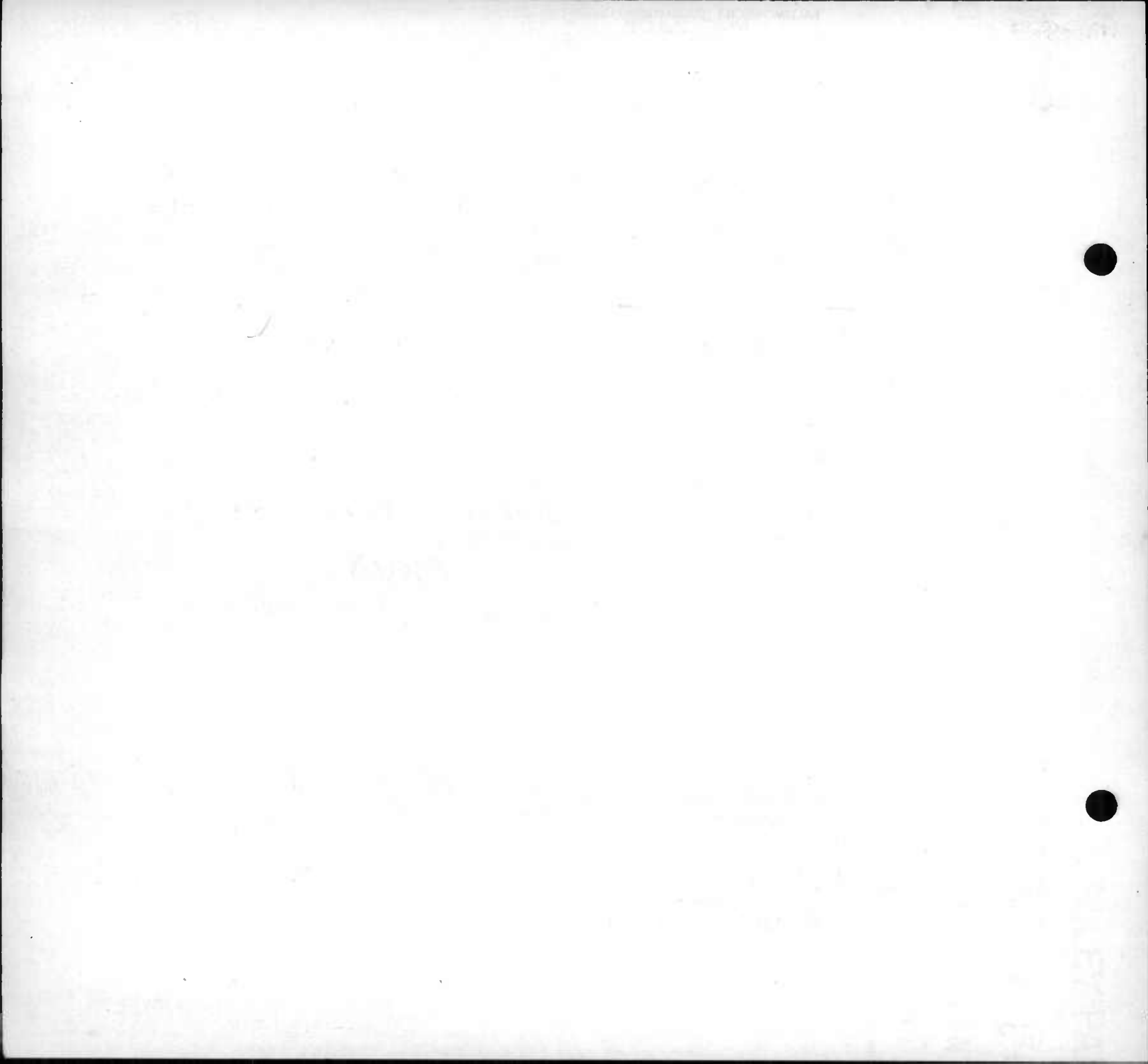
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1108

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-1108

BIRTH NO.		1. NAME OF DECEASED (Type or Print) CHARLOTTE C. MENTON		2. DATE AND HOUR OF DEATH 1/25/68 11:40 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48th GENERAL HOSP.				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY	
5. SEX F		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		8. DATE OF BIRTH 11/04/07	
13. FATHER'S NAME JAMES CLARK		14. MOTHER'S MAIDEN NAME Dorothy Pfaar		9. AGE (In years last birthday) 60	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ?		11. BIRTHPLACE (State or foreign country) BALTO Md.	
17. INFORMANT husband JOHN A. MENTON		ADDRESS Same		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
18. 412.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) SHOCK ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. SEVERE HEART FAILURE				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
19. 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). HYPOXIA DUE TO BRONCHO-PNEUMONIA					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/25 1968 to 1/25 1968 , and that (I) (we) last saw the deceased alive on 1/25 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. N. MAURITIS				23B. DATE SIGNED 1/25/68	
23C. PHYSICIAN'S NAME (Type) A. N. MAURITIS				23D. ADDRESS Md. GEN. HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/29/68		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968		25B. NAME OF REGISTRAR C. E. E. E.		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.	
				ADDRESS 3331 Brehms Lane	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1109

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-1109

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

BUSSELLS, Mr. LOUIS Denis

2. DATE AND HOUR OF DEATH

1/24/68 at 10:05 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

48 Maryland Gen. Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MD.

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

2730, Pelham Avenue

5. SEX

M

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

11/30/94

9. AGE (In years
last birthday)

73

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Carrier Nam

10B. KIND OF BUSINESS OR INDUSTRY

U.S. Post Office

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

MARION BUSSELLS

14. MOTHER'S MAIDEN NAME

? unknown

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

WW 1 - Army

16. SOCIAL
SECURITY NO.

218 402369

17. INFORMANT

Mamie (nee Woods) Bussells, wife, above

ADDRESS

18. 484X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

Cardio-respiratory
failure

(B)
DUE TO, OR AS A CONSEQUENCE OF:

Pneumonia

(C)
DUE TO, OR AS A CONSEQUENCE OF:

E Seizures

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

492X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐
Work

Not While ☐
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from

1/21/68 to

1/24/68

that (I) (we) last saw the deceased alive on

1/24/68

and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

S. Swaroop MD.

Attending
Phys. ☐

Med.
Director ☐

Staff
Phys. ☒

23B. DATE SIGNED

1/24/68

23C. PHYSICIAN'S
NAME (Type)

S. SWAROOP MD.

23D. ADDRESS

Maryland Gen. Hospital

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1/29/68

24C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cemetery

24D. LOCATION

Baltimore, Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 29 1968

25B. NAME OF REGISTRAR

Robert E. Fickens

25C. FUNERAL DIRECTOR

Schimune Funeral Home, Inc.

ADDRESS

3331 Brehms Lane

11/30/44 5332
W. M. X

RM

11/30/44 5332
W. M. X

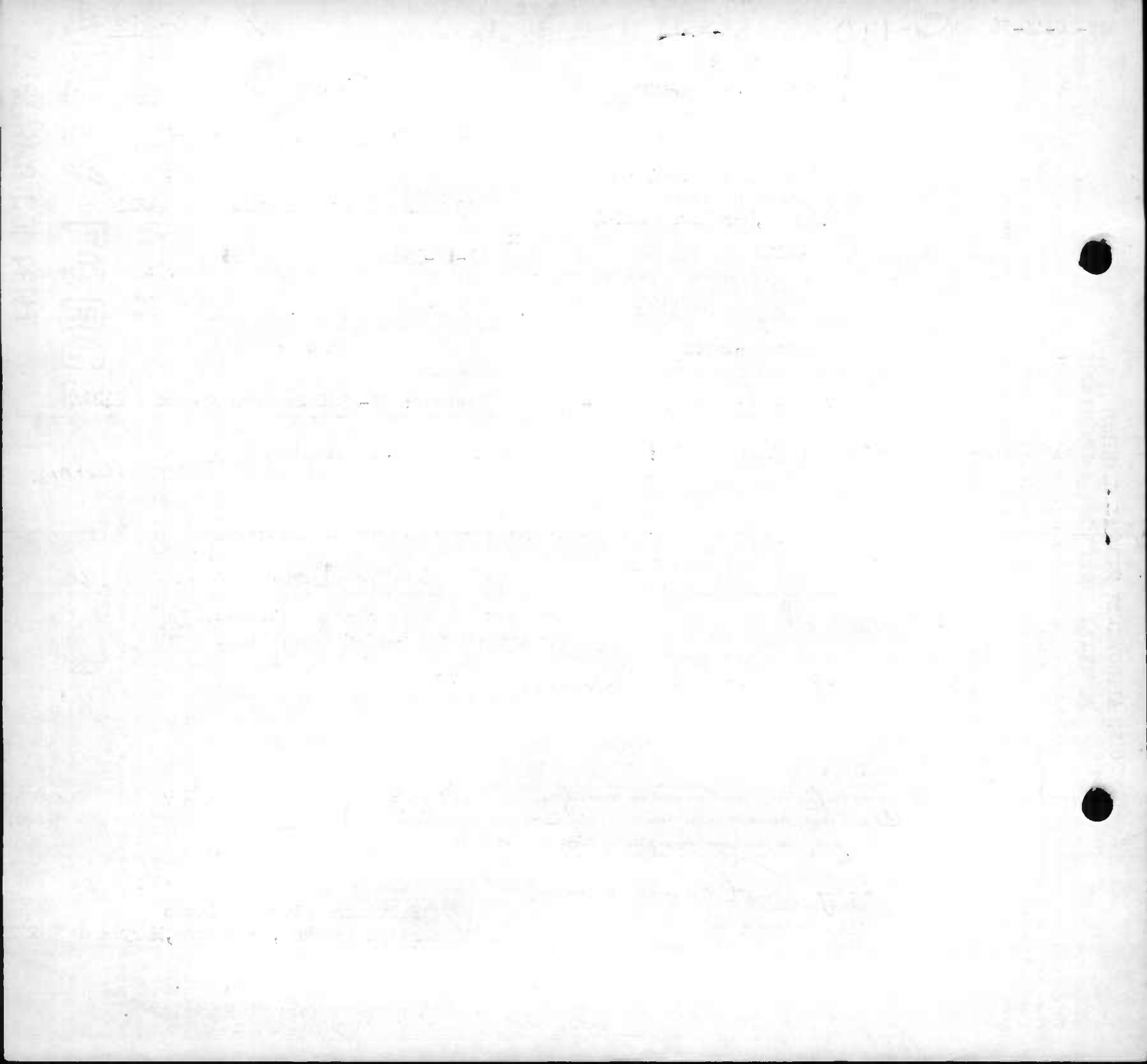
11/30/44 5332
W. M. X

11/30/44 5332
W. M. X

11/30/44 5332
W. M. X

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

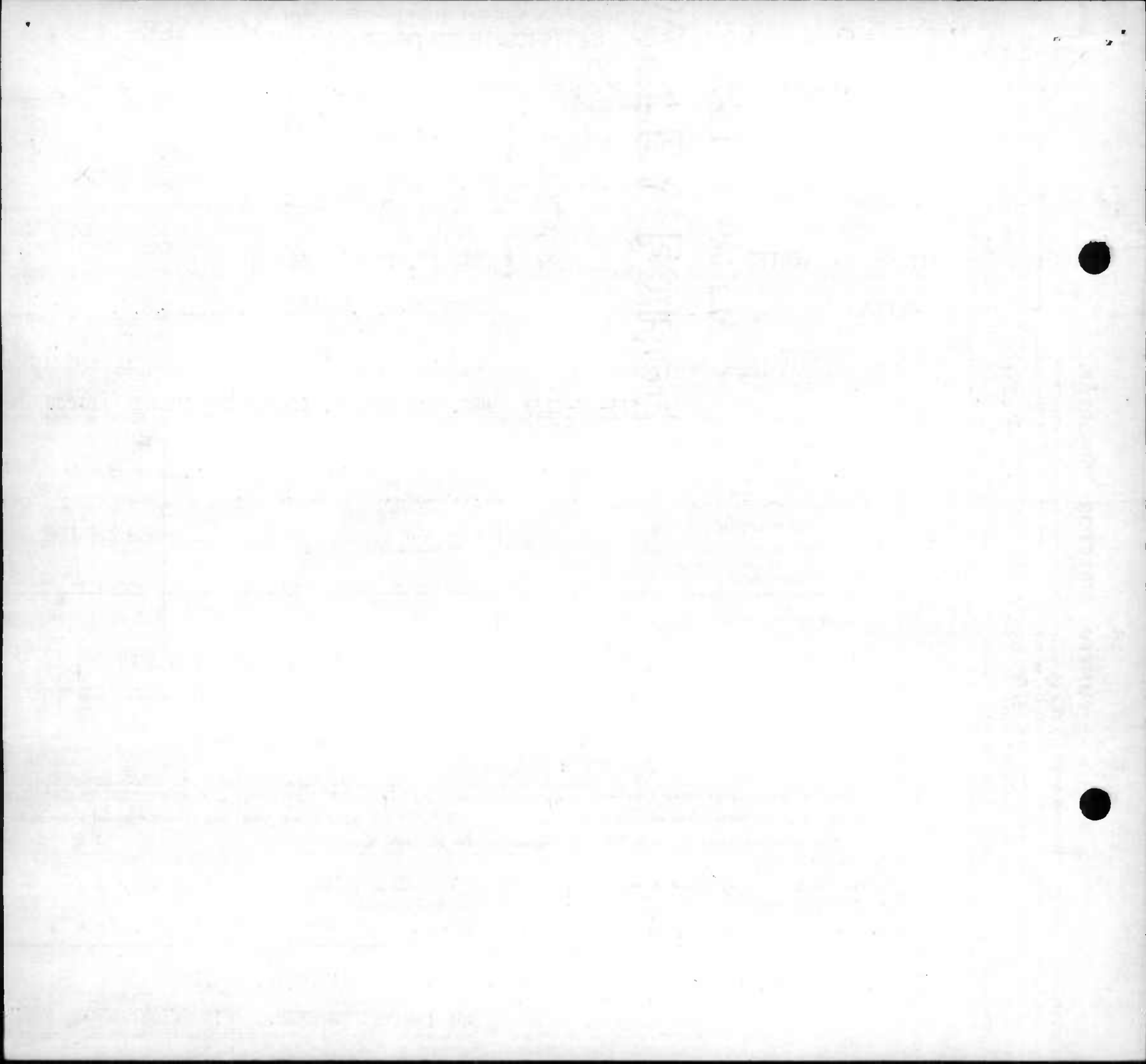
0-110		68-1110		CITY HEALTH DEPARTMENT		REG. NO. 68-1110	
BIRTH NO.				1. NAME OF DECEASED (Jaroslav) JERRY L. OPAVA			
2. DATE AND HOUR OF DEATH 7:30 AM. 1/24/68				7:30 PM.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				C. CITY OR TOWN D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX Male 6. RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 11-5-1912 9. AGE (In years lost birthday) 55			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver				10B. KIND OF BUSINESS OR INDUSTRY Pollard Cab Co.			
11. BIRTHPLACE (State or foreign country) Baltimore, Md.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Bohamil Opava Frank				14. MOTHER'S MAIDEN NAME Anna Rmoutil			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW2 - Army				16. SOCIAL SECURITY NO. 218-69-5464			
17. INFORMANT				ADDRESS Records: BCH-4940 Eastern Avenue 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pseudomonas Septicemia				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 days			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last. Broucho pneumonia				20. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (A) Lye Ingestion 1/8/68			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Pancreatitis; Renal failure; Arteriosclerotic Heart Dis.				22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
19A. DATE OF OPERATION 1/12/68				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Rekt abdomen			
20A. AUTOPSY? (Yes or No) YES				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 4940 Eastern Avenue				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 1 8 68 -			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>				21F. HOW DID INJURY OCCUR? INTENTIONAL INGESTION of Lye			
22. I certify that (1) (this hospital) attended the deceased from 1/8/68 to 1/24/68, and that (2) (we) lost saw the deceased alive on 1/24/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Philip Coleman, M.D.				23B. DATE SIGNED 1/24/68			
23C. PHYSICIAN'S NAME (Type) Philip Coleman				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 1/26/68			
24C. NAME OF CEMETERY or CREMATORY Bohemian National Cem.				24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968				25B. NAME OF REGISTRAR Robert E. Fisher			
25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.				ADDRESS 3331 Brehms Lane			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

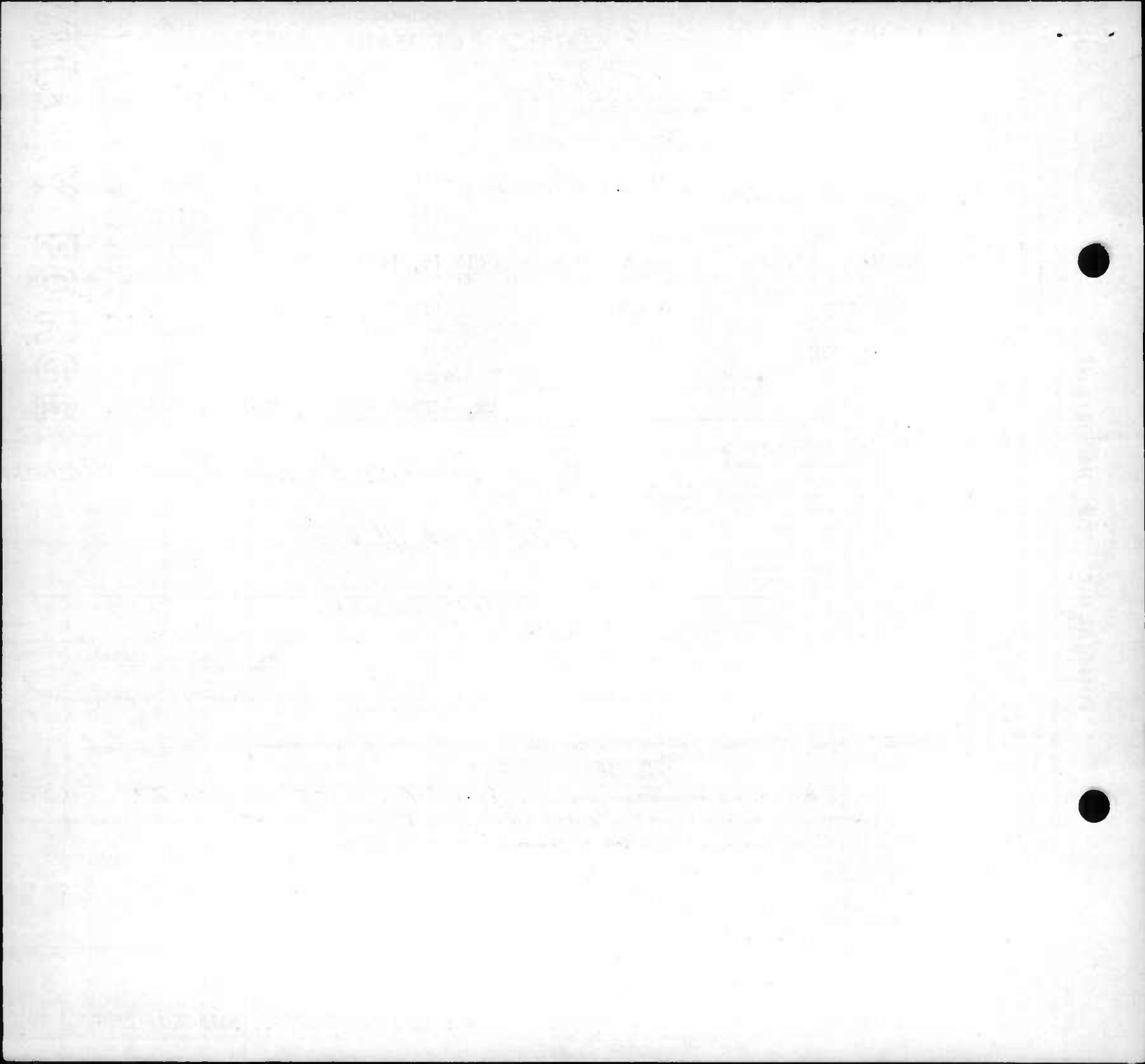
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
REG. NO. 68-1111									
BIRTH NO. 5-600 68-1111									
1. NAME OF DECEASED (Type or Print) SCHERR, IRVING JOSEPH					2. DATE AND HOUR OF DEATH 1/26/68 6-10 P.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL OF BALTIMORE					A. STATE MARYLAND B. COUNTY Baltimore				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN BALTIMORE			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
					E. STREET AND NUMBER 2306 SMITH AVENUE #21209				
5. SEX MALE m	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 25, 1901 68	9. AGE (In years last birthday)		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED			10B. KIND OF BUSINESS OR INDUSTRY SALESMAN		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ABRAHAM SCHERR					14. MOTHER'S MAIDEN NAME SOPHIA ?				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 215-07-6223		17. INFORMANT MRS. RAY SCHERR, 2306 SMITH AVENUE #21209				
18. 410.91 CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction					acute				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD					3 YRS				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 420.1 II									
19A. DATE OF OPERATION D			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (1) (this hospital) attended the deceased from 19 65 to 1/26 19 68 , that (1) (we) last saw the deceased alive on Dec 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
23A. SIGNATURE Leon S. Sheer, M.D.					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 1/26/68	
23C. PHYSICIAN'S NAME (Type) LEON G. SHEER, M.D.					23D. ADDRESS 6715 PARK HEIGHTS AVE				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-28-68		24C. NAME OF CEMETERY or CREMATORY HEBREW YOUNG MENS		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. JAN 28 1968			25B. NAME OF REGISTRAR P. E. E. Talley		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 1112	
6432 68- 1112		BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Phoebe Goldstein</i>	
2. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		2. DATE AND HOUR OF DEATH <i>JAN 25 1968 8¹⁵ P.M.</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Sinai Hospital of Baltimore</i>		A. STATE B. COUNTY <i>MARYLAND</i>		C. CITY OR TOWN <i>BALTIMORE</i>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <i>3104 GRANADA AVENUE #21207</i>	
5. SEX <i>FEMALE</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JULY 15, 1889</i>	9. AGE (In years lost birthday) <i>78</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>		11. BIRTHPLACE (State or foreign country) <i>BALTIMORE, MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>JOSEPH COHEN</i>		14. MOTHER'S MAIDEN NAME <i>ROSA ?</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>MR. ARTHUR MERICAN, 4101 COLONIAL RD. #21208</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) <i>412.01</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 hours</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <i>420.1 II</i>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pulmonary Embolus - Suspect</i>			
		(B) <i>ASCVN + HCVN</i> DUE TO, OR AS A CONSEQUENCE OF:			
		(C) <i>(1) Electrolyte Imbalance</i> <i>(2) History of old myocardial infarction</i>		<i>2 days</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from <i>Jan 24 1968</i> to <i>Jan 25 1968</i> , that (I) (we) last saw the deceased alive on <i>Jan 23 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.					
23A. SIGNATURE <i>E. H. LAZAR</i>		23B. DATE SIGNED <i>Jan 25, 1968</i>		23C. PHYSICIAN'S NAME (Type) <i>E. H. LAZAR</i>	
23D. ADDRESS <i>SINAI HOSPITAL</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>1-26-68</i>	
24C. NAME OF CEMETERY or CREMATORY <i>MOGAN ABRAHAM</i>		24D. LOCATION <i>BALTIMORE, MARYLAND</i>		24E. DATE REC'D BY HEALTH DEPT. <i>JAN 29 1968</i>	
24F. NAME OF REGISTRAR <i>Robert E. Farkner</i>		24G. FUNERAL DIRECTOR <i>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</i>		24H. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 2-240				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1113	
1. NAME OF DECEASED (Type or Print) ZWAGIL SARAH				2. DATE AND HOUR OF DEATH 1-25-68 01-12-15 PM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital of Balto. M.D.				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND COUNTY BALTIMORE C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4601 PALL MALL ROAD #21215			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-11-1896	9. AGE (In years, months, days) 71-11-15	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUSSIA		
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME LOUIS MILLER				
14. MOTHER'S MAIDEN NAME MIRIAM ?			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO.			17. INFORMANT MR. MORRIS ZWAGIL, 3420 VARGAS CIRCLE #21207				
18. 553.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Cardiac arrest				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Pneumonia - bilateral pleural effusion			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(C) Strangled femoral artery			
21A. DATE OF OPERATION 1-14-68		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED Strangled femoral artery		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		21G. DATE SIGNED 1-25-68		21H. SIGNATURE ARSHAD SAED	
22. I certify that (I) (this hospital) attended the deceased from 1/14/68 to 1/25/68 and that (I) (we) last saw the deceased alive on 1/25/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		23A. SIGNATURE ARSHAD SAED		23B. DATE SIGNED 1-25-68		23C. PHYSICIAN'S NAME (Type) ARSHAD SAED	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-28-68		24C. NAME OF CEMETERY or CREMATORY LUBOWITZ		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		25D. ADDRESS	

2240 2400

1/2

1/2

1/2

1/2

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1114

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-1114

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Sadie Stock

2. DATE AND HOUR OF DEATH

27 Jan 68

1

15

P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

60 1104 West Pratt Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1104 West Pratt Street

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

March 29, 1895

72

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George Jackson

14. MOTHER'S MAIDEN NAME

Josephine Hall

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

ADDRESS

Mrs. Margaret Sly 1104 W. Pratt Street

18.

436.9 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

Cerebro-vascular accident

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

2 1/2 hrs

15 yrs

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

None

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 27 Jan 19 68 to 27 Jan 19 68,
that (1) (we) lost saw the deceased alive on 27 Jan 19 68 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Gerald A Miller MD

DEGREE

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

27 Jan 68

23C. PHYSICIAN'S
NAME (Type)

Gerald A. Miller

DEGREE

23D. ADDRESS

2032 Wilkens Ave

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1-30-68

24C. NAME OF CEMETERY or CREMATORY

Lorraine Cemetery

24D. LOCATION

Woodlawn

(City, town, or county)

Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 29 1968

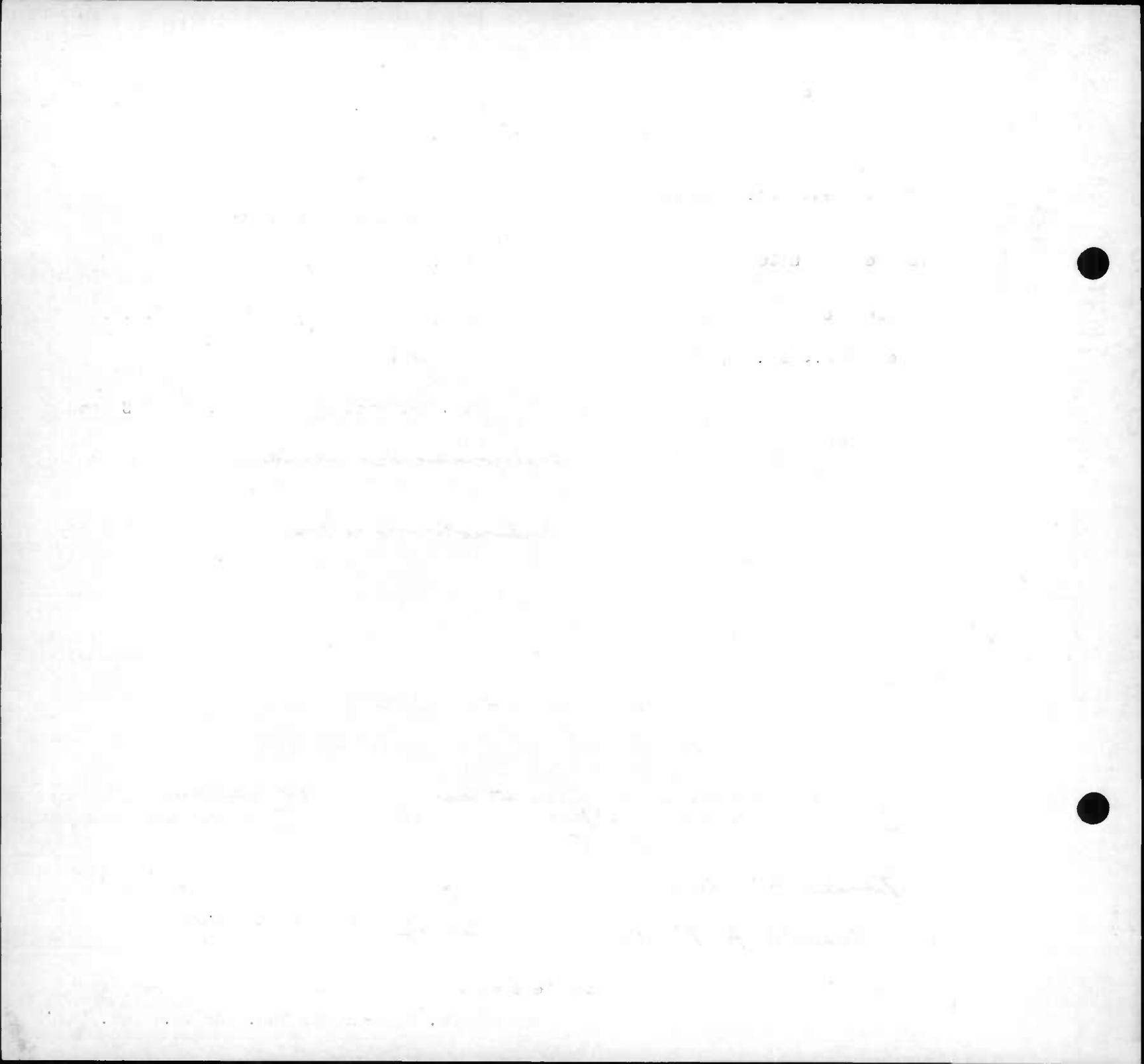
25B. NAME OF REGISTRAR

Robert E. Jenkins

25C. FUNERAL DIRECTOR

Wm. Cook-Brooks Inc. Balto., Md. 21202

ADDRESS



68-1115

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-1115

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

WALTER K. KRAMER

2. DATE OF DEATH

Known ☒ Estimated ☐

Month 1 Day 24 Year 68

Hour 3:10 a

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

60 3113 St. Paul St.

3. DATE PRONOUNCED DEAD

Month January Day 24 Year 1968

Hour 3:10 a

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

12-02

6. SEX

Male

7. RACE

White

8. MARRIED

☐ NEVER MARRIED

WIDOWED

☐ DIVORCED

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

10-1-1895

10. AGE (In years last birthday)

72

11. Under 1 Yr. 12 Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

3113 St. Paul St.

11. BIRTHPLACE (State or foreign country)

St. Louis, Mo.

12. CITIZEN OF WHAT COUNTRY?

XX USA

13. FATHER'S NAME

~~XXXXXXXXXXXX~~ Unknown

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Carpenter

14B. KIND OF BUSINESS OR INDUSTRY

Building

15. MOTHER'S MAIDEN NAME

Unknown

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW I

17. SOCIAL SECURITY NO.

212-10-7036

18. INFORMANT

ADDRESS

Eva Kramer 1004 Keats Ave. Orlando, Fla.

19.

412.91

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

422.1

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 24, 1968

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1-29-1968

24C. NAME OF CEMETERY or CREMATORY

Balto. Nat'l Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Balto., Md. 21202
Wm. Cook-Brooks, Inc. 1217 St. Paul St.

1. The first part of the document is a letter from the President of the United States to the Congress.

2. The second part is a report on the state of the Union.

3. The third part is a report on the state of the Treasury.

4. The fourth part is a report on the state of the Navy.

5. The fifth part is a report on the state of the Army.

6. The sixth part is a report on the state of the Commerce.

7. The seventh part is a report on the state of the Education.

8. The eighth part is a report on the state of the Agriculture.

9. The ninth part is a report on the state of the Fisheries.

10. The tenth part is a report on the state of the Arts.

11. The eleventh part is a report on the state of the Sciences.

12. The twelfth part is a report on the state of the Literature.

13. The thirteenth part is a report on the state of the Music.

14. The fourteenth part is a report on the state of the Painting.

15. The fifteenth part is a report on the state of the Sculpture.

16. The sixteenth part is a report on the state of the Architecture.

17. The seventeenth part is a report on the state of the Engineering.

18. The eighteenth part is a report on the state of the Medicine.

19. The nineteenth part is a report on the state of the Law.

20. The twentieth part is a report on the state of the Religion.

21. The twenty-first part is a report on the state of the Philosophy.

22. The twenty-second part is a report on the state of the History.

23. The twenty-third part is a report on the state of the Geography.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1116

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-1116

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Gaston Hair

2. DATE AND HOUR OF DEATH

1-24-68

7:20 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Mercy Hospital.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS

YES ☒

NO ☐

E. STREET AND NUMBER

127 1/2 E. North Avenue

5. SEX

M

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

2-11-26

9. AGE (In years last birthday)

41

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Disabled

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

NORTH CAROLINA

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

PRES

HAIR

14. MOTHER'S MAIDEN NAME

Edith E. Care

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

??

16. SOCIAL SECURITY NO.

240-30-1517

17. INFORMANT

Laura Nell Onsted

ADDRESS

127 E. North ave Balto, Md.

18. 5-71-01

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

Renal Failure

9 days

(B) Hepatic Coma DUE TO, OR AS A CONSEQUENCE OF:

Hepatic Coma

12 days

(C) Acute Alcoholic Cirrhosis

Acute Alcoholic Cirrhosis

1965

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

1-23-68

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

Peritoneoscopy Jaundice

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-14-1968 to 1-24-1968, that (we) last saw the deceased alive on 1-23-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Beatrice A. Deneffield, M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1-24-68

23C. PHYSICIAN'S NAME (Type)

Beatrice A. Deneffield

23D. ADDRESS

Mercy Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

Removal 1-26-1968

24C. NAME OF CEMETERY OR CREMATORY

Lee Fan Home

24D. LOCATION

(City, town, or county)

(State)

Fayetteville, North Carolina

25A. DATE REC'D BY HEALTH DEPT.

JAN 29 1968

25B. NAME OF REGISTRAR

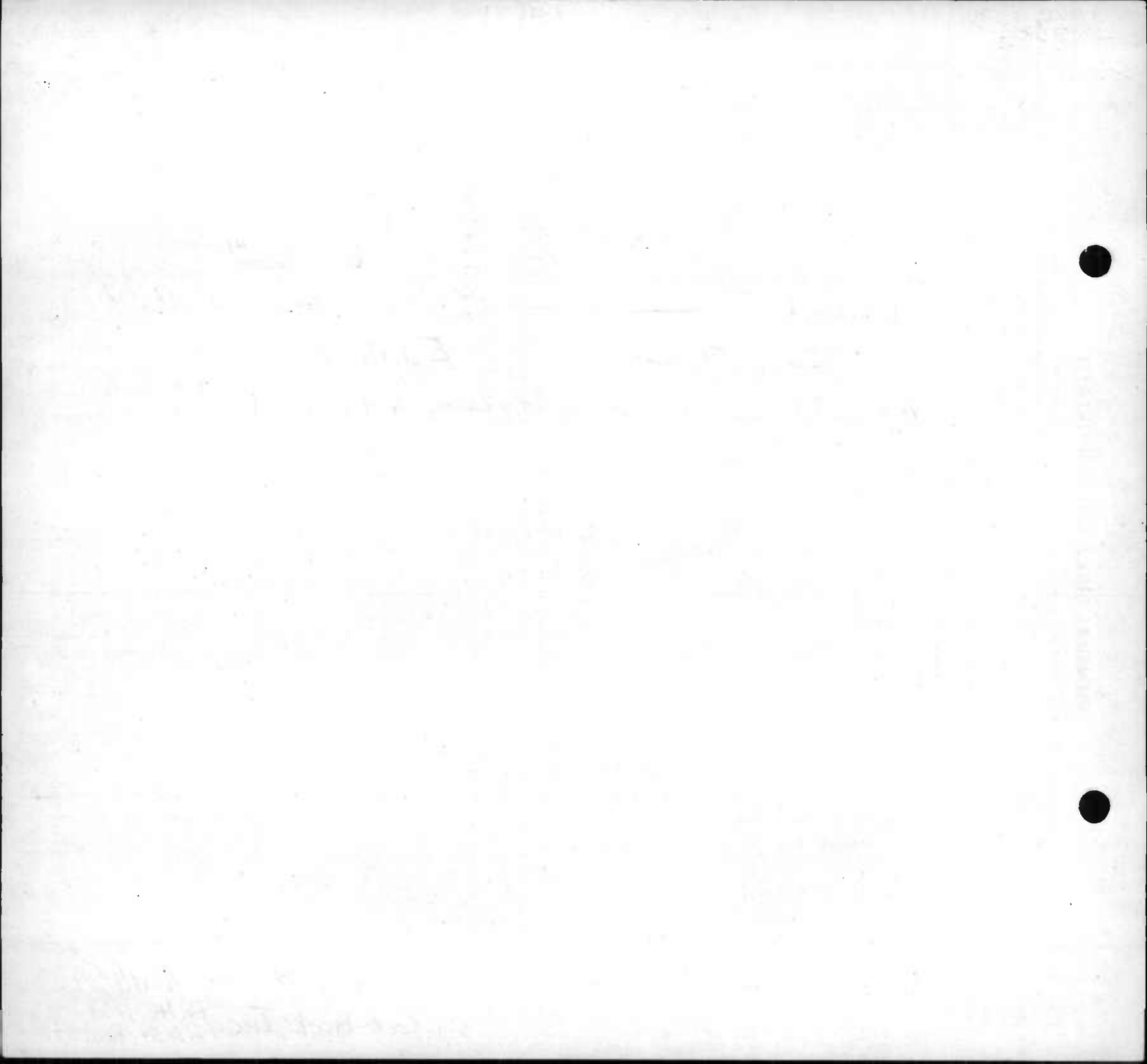
Robert E. Johnson

25C. FUNERAL DIRECTOR

Wm. Cook-Brooks, Inc. Balto., Md.

ADDRESS

1017 St. Paul St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				68-1117		68-1117	
CERTIFICATE OF DEATH				REG. NO.			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		E. Edward Wheeler		1-28-68		844 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 Union Memorial Hospital				A. STATE 3330 Elmore md.		B. COUNTY	
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3330 Elmore Ave.							
5. SEX m	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-4-82	9. AGE (In years last birthday) 85	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown John T. Wheeler				14. MOTHER'S MAIDEN NAME UNKNOWN Susan V. Clocker			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes Spanish-Amer.		16. SOCIAL SECURITY NO. 212-52-6577		17. INFORMANT Mrs. Katherine Klein		ADDRESS 10. AS DECEASED	
18. CAUSE OF DEATH 485X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 491X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: BRONCHO PNEUMONIA 14 DAYS (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JANUARY 27 19 68 to JANUARY 28 19 68, that (I) (we) last saw the deceased alive on JANUARY 28 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Enrique Cipriani MD				23B. DATE SIGNED 1/28/68		23C. PHYSICIAN'S DEGREE	
23D. ADDRESS DR ENRIQUE CIPRIANI CIPRIANI MD, THE UNION MEMORIAL HOSPITAL							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/31/68		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968		25B. NAME OF REGISTRAR R. E. Feinberg		25C. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc. 1217 St. Paul St.		ADDRESS	

General Hospital

General

2330 Elmwood Ave

2-4-43

X

W

M

Unknown

Unknown

General Hospital

W

General Hospital

X

General Hospital

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1118 BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 1118	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Cruikshank, MARY</u>		2. DATE AND HOUR OF DEATH <u>1-27-68</u> <u>9 P.m.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>13-07</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>11 Keewick</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>700 W. 40th St.</u>	
5. SEX <u>FEMALE</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 20, 1880</u>	9. AGE (In years last birthday) <u>88</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas Cruikshank</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Wallace</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-32-1157A</u>		17. INFORMANT <u>M. R. Gundry</u> ADDRESS <u>Keewick</u>	
18. <u>492X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia</u> (B) <u>Emphysema</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Years</u>	
19. <u>3-27-1</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>Arteriosclerotic CV disease</u>		<u>Years</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>MAR. 9</u> 19 <u>66</u> to <u>JAN. 27</u> 19 <u>68</u> , that (1) (we) last saw the deceased alive on <u>1/26</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dr. Richard K. Gundry</u>				23B. DATE SIGNED <u>1/28/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>RK Gundry</u>				23D. ADDRESS <u>700 W. 40th St. Balto. Md. 21211</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		24B. DATE <u>1/29/68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>M. Williams F.H.</u>	
24D. LOCATION <u>Chestertown, Md.</u>		24E. FUNERAL DIRECTOR <u>Wm. Cook-Brooks, Inc.</u>		24F. ADDRESS <u>1217 St. Paul St.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 29 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>		25C. FUNERAL DIRECTOR <u>Wm. Cook-Brooks, Inc.</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1119

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 1119

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Thomas F Mallory

2. DATE AND HOUR OF DEATH

Jan 26, 1968 11:59 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

E. STREET AND NUMBER

Baltimore
2003 Dukeland St.

5. SEX

MALE

6. RACE

Colored

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

01-21-17

9. AGE (In years last birthday)

51

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

invest. clerk

10B. KIND OF BUSINESS OR INDUSTRY

U.S. Govt. Sec. Sec.
Woodlawn, Md.

11. BIRTHPLACE (State or foreign country)

BALTIMORE, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

THUURRON MALLORY, SR.

14. MOTHER'S MAIDEN NAME

IANTHE CLARK

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

YES

WW-II

16. SOCIAL SECURITY NO.

215-18-7171

17. INFORMANT

Mrs. IRENE B. MALLORY 2003 Dukeland St

ADDRESS

18. 153.8 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

Carcinomatosis

(B) DUE TO, OR AS A CONSEQUENCE OF:

Adenocarcinoma of Colon

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 year

153.8 II

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

31-2-68

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

Intestinal Obstruction

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

No

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from December 29 1967 to January 26 1968, that (I) (we) last saw the deceased alive on January 26 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Crile Crile, M.D.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

1/27/68

23C. PHYSICIAN'S NAME (Type)

CRILE CRISLER M.D.

23D. ADDRESS

JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

1/31/68

24C. NAME OF CEMETERY OR CREMATORY

BALTIMORE NATIONAL Cem

24D. LOCATION

BALTIMORE

(City, town, or county)

(State)

MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

JAN 29 1968

25B. NAME OF REGISTRAR

Herbert E. Fidler, M.D.

25C. FUNERAL DIRECTOR

HERBERT E. NUTTEN 3035 W. NORTH AVE

ADDRESS

Thomas F. Halliday

Johns Hopkins Hospital

Male (colored)

U.S. Inst. 22-24
Woodrow, Md.

inst. 22-24

2003 Duke Lane St
Baltimore, Maryland U.S.A.

01-21-17 21

Baltimore, Maryland U.S.A.

Yes: WW-II

212-18-1111 Mr. James R. Miller, 2003 Duke Lane

Carcinoma

Adenocarcinoma of Colon

1-5-68 Tubercular Osteitis

No

No

January 26
December 26

21 Toward St

X

Dr. J. B. ...
Baltimore, Md.
Robert E. ...

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-1120

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EUGENE PALMER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> January 22, 1968 5:20 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 807 Pennsylvania Avenue (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour January 22, 1968 5:20 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 9-8-1934		10. AGE (In years last birthday) 33	
11. BIRTHPLACE (State or foreign country) Oklahoma City, Oklahoma		12. CITIZEN OF U.S.A.	
13. FATHER'S NAME Arthur Palmer		14. MOTHER'S MAIDEN NAME Lula Banks	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		18. SOCIAL SECURITY NO.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Purulent Peritonitis Due to Rupture of Duodenal Ulcer ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Partial OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
24. ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		25. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
26A. BURIAL CREMATION, REMOVAL (Specify) Burial		26B. DATE 1-28-68	
26C. NAME of CEMETERY or CREMATORY Hill Crest Gardens		26D. LOCATION (City, town, or county) (State) Oklahoma City, Oklahoma	
27A. DATE REC'D BY HEALTH DEPT. JAN 29 1968		27B. NAME OF REGISTRAR Robert E. Taylor	
27C. FUNERAL DIRECTOR Walter Rolfe - 1801 N.E. 10th St. Oklahoma City, Oklahoma		27D. ADDRESS 73117	

VALLEY BOY

VALLEY BOY

MENT

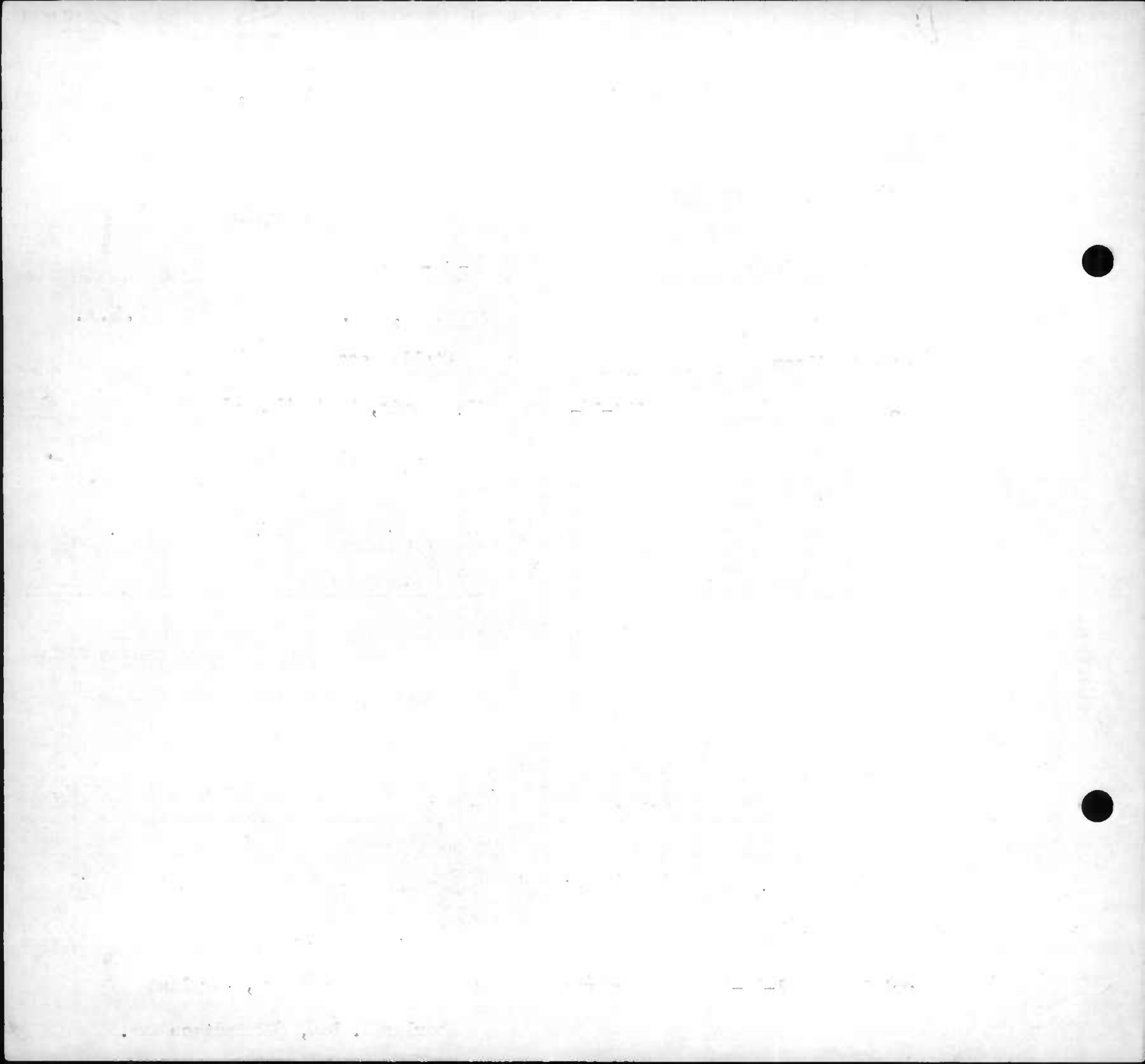
Valley Boy

2115

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-1121</u>
B-120 68-1121		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
SARAH JONES DAVIS		January 25, 1968 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived: If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 3804 Hillside Road		A. STATE Maryland		
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Female		6. RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-24-1921
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 46
13. FATHER'S NAME Joseph Wilson		11. BIRTHPLACE (State or foreign country) Freeman, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-26-2882		17. INFORMANT Miles Davis, 3804 Hillside Road
18. 404X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory Failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertensive Cardiac Vascular		(B) DUE TO OR AS A CONSEQUENCE OF Renal Disease		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 442X II				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from August 2, 1967 to Jan 25, 1968 , that (I) (we) last saw the deceased alive on Oct 17, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE L. Shorofsky MD				23B. DATE SIGNED 1/26/68
23C. PHYSICIAN'S NAME (Type) SPBOROFSKY		23D. ADDRESS 4734 Park Heights Parkway MD		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-30-68		24C. NAME OF CEMETERY or CREMATORY Arubuts Mem Park
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968		
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Charles R. Law, 802 Madison Ave.		



B-255 68-1122

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-1122

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIE MAE BOZEMAN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> January 25, 1968 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 500 Dolphin Street		3. DATE PRONOUNCED DEAD Month Day Year Hour January 25, 1968 1:12 A.M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 17-02	
9. DATE OF BIRTH 9-26-1902		10. AGE (In years last birthday) 65	
11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF U.S.A.	
13. FATHER'S NAME James Miller		14. MOTHER'S MAIDEN NAME Tabitha Wynn	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beautician		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		18. SOCIAL SECURITY NO. 212-20-6602	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 162.1 I Carcinoma of lung (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 163X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED January 25, 1968 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-29-68	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Charles R. Law		ADDRESS 802 Madison Ave.	

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1861.

2. The second part is a report from the Secretary of the Treasury, dated January 1, 1861.

3. The third part is a report from the Secretary of the Interior, dated January 1, 1861.

4. The fourth part is a report from the Secretary of the Navy, dated January 1, 1861.

5. The fifth part is a report from the Secretary of the War, dated January 1, 1861.

6. The sixth part is a report from the Secretary of the State, dated January 1, 1861.

7. The seventh part is a report from the Secretary of the War, dated January 1, 1861.

8. The eighth part is a report from the Secretary of the War, dated January 1, 1861.

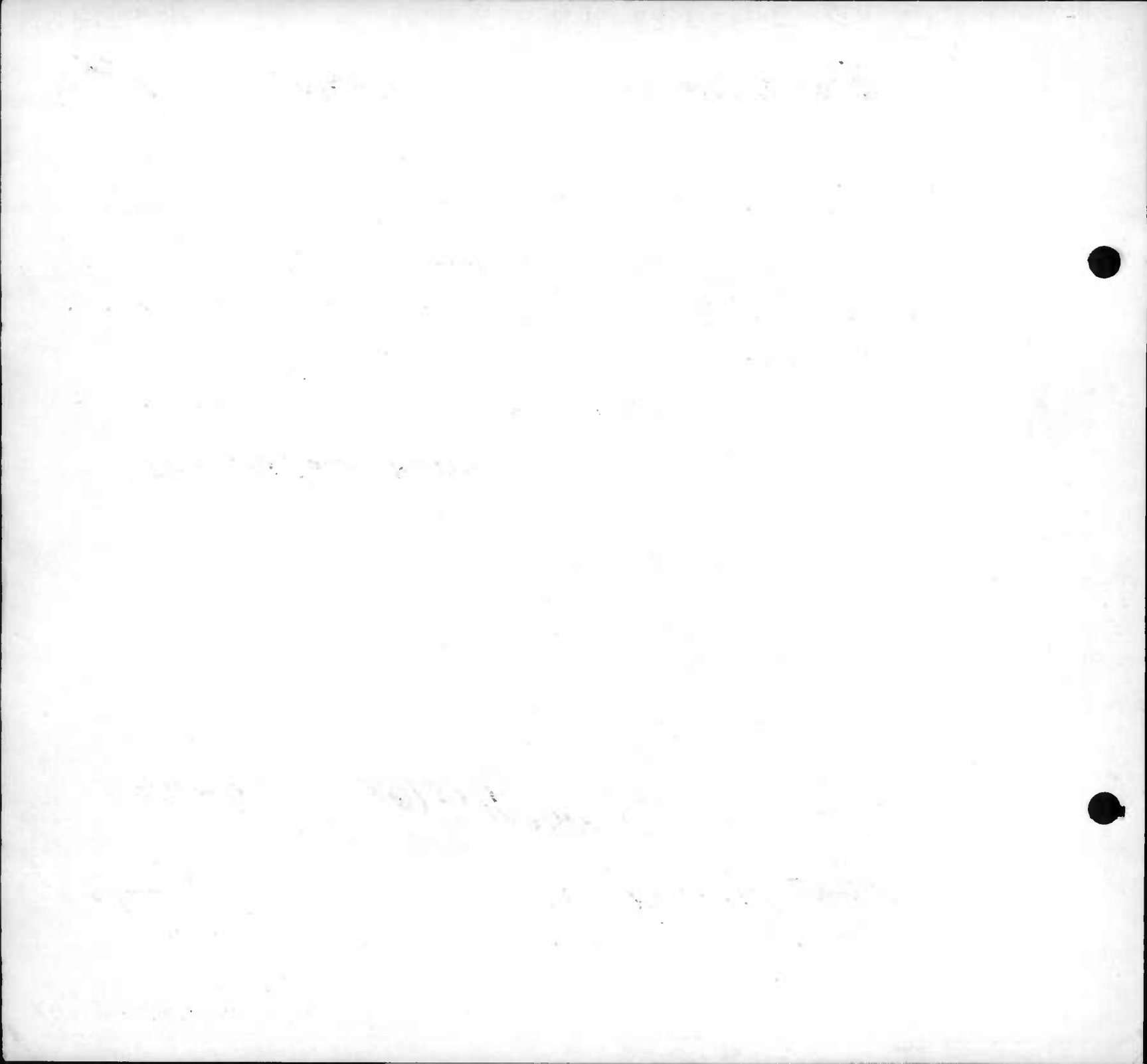
9. The ninth part is a report from the Secretary of the War, dated January 1, 1861.

10. The tenth part is a report from the Secretary of the War, dated January 1, 1861.

11. The eleventh part is a report from the Secretary of the War, dated January 1, 1861.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650 68-1123				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1123	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		Brown, Buck		2. DATE AND HOUR OF DEATH 1/24/68 7:58 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 25-06			
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1530 CHESAPEAKE AVENUE 21226							
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-3-98	9. AGE (In years last birthday) 69	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME JOSEPH BROWN				14. MOTHER'S MAIDEN NAME MAZAREINE SUMPTER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 221-107965A		17. INFORMANT 4940 EASTERN AVENUE BCH RECORDS: BALTIMORE, MD. 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 157X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). CAUSE OF DEATH Carcinoma, Pancreas (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Nat While <input type="checkbox"/> Work At Work		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (his hospital) attended the deceased from 1/15/68 19 to 1/24/68 19, that (I) (we) last saw the deceased alive on 1/24/68 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Robert N. Hill MD				23B. DATE SIGNED 1/24/68			
23C. PHYSICIAN'S NAME (Type) ROBERT N. HILL				23D. ADDRESS M. D. DEGREE 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224			
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-28-68		24C. NAME of CEMETERY or CREMATORY GEORGETOWN S. C.		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR JOSEPH KNIGHT 1639 N. BROADWAY			



1
B-630

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. <u>67-25564</u>		REG. NO. _____	
1. NAME OF DECEASED (Type or Print) CHRISTOPHER BYRD		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> January 25, 1968 10:35 A	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 Hopkins Hospital (If not in hospital or institution, give street address or location)		3. DATE PRONOUNCED DEAD Month Day Year Hour January 25, 1968 10:35 A.M.	
6. SEX Male		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 807	
7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
9. DATE OF BIRTH 12-15-67	10. AGE (in years, months, days, hours, minutes) 5 weeks	E. STREET AND NUMBER EL 1305 N. Chaple Street	
11. BIRTHPLACE (State or foreign country) md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME WILLIAM BYRD JR.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME Shirley's EDWARDS	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	17. SOCIAL SECURITY NO. _____	18. INFORMANT ADDRESS WM Byrd Jr. 1305 N. CHAPEL ST	
19. 0367 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Septicemia (SDII) Sudden-death-in-infancy		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 053.4 II			
20A. DATE OF OPERATION 2	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED January 25, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIE	24B. DATE 1-27-68	24C. NAME OF CEMETERY or CREMATORY MT CALVARY	24D. LOCATION (City, town, or county) (State) a a COUNTY Md
25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968	25B. NAME OF REGISTRAR P. E. E. F. F.	25C. FUNERAL DIRECTOR ADDRESS JOSEPH KNIGHT 1639 N. BROADWAY	

Letter from M.E.'s office

2-8-68

M.H.

VALLEY FORGE

25% WAS CONTENT

68- 1125

BALTIMORE CITY HEALTH DEPARTMENT

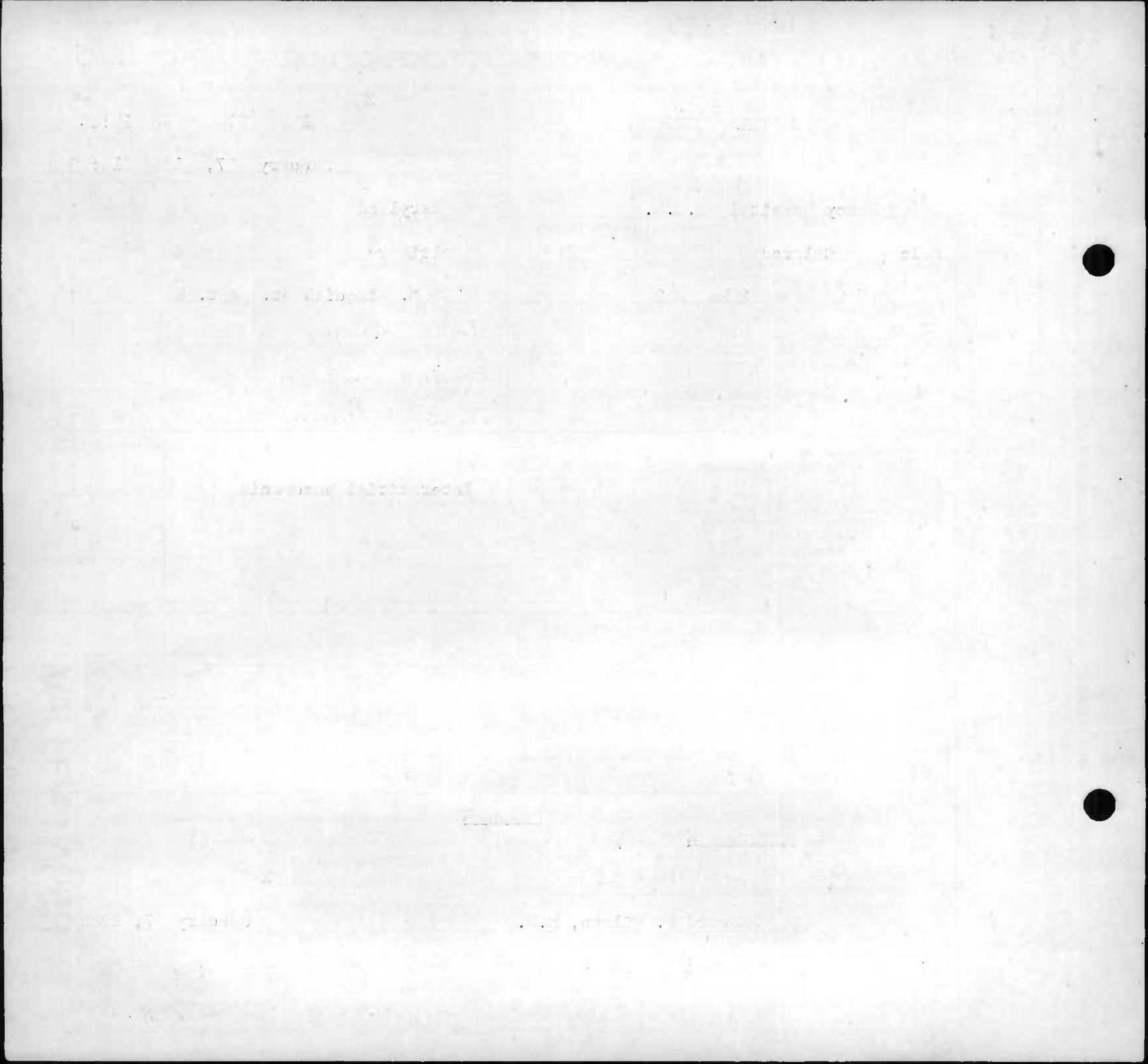
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 1125

REG. NO.

BIRTH NO. 67-23963

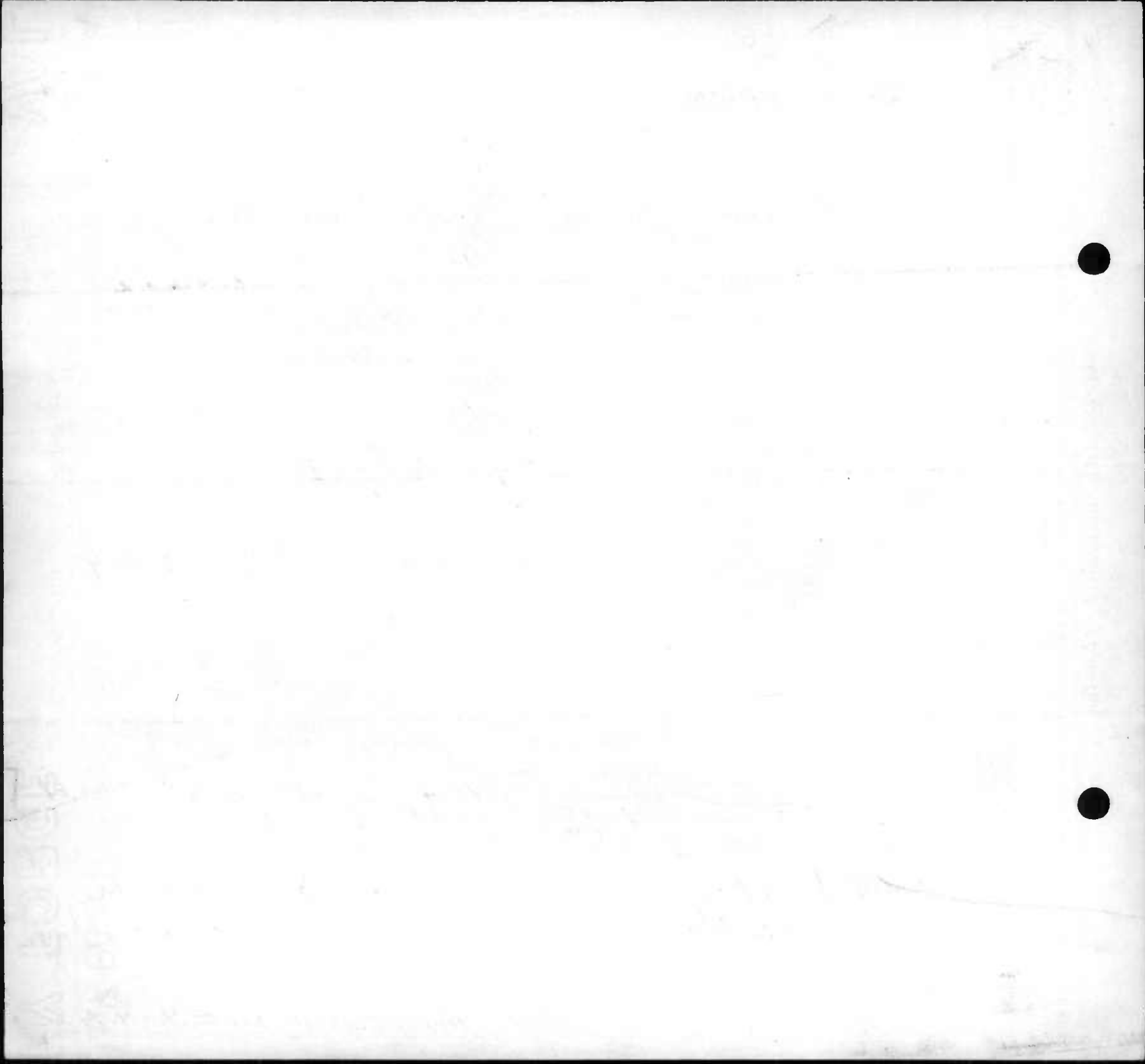
1. NAME OF DECEASED (Type or Print) B. SAMUEL BURNHAN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 1 27 68 10:00 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 349 Mercy Hospital D.O.A.		3. DATE PRONOUNCED DEAD Month Day Year Hour January 27, 1968 10:00 a.m.	
6. SEX Male	7. RACE Colored	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 11-30-67		10. AGE (in years lost birthday) 2 Mo 2	
11. BIRTHPLACE (State or foreign country) Balti, Md.		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME Jacklin Burnham		18. INFORMANT ADDRESS Jacklin Burnham 200 Aisquith St.	
19. 484X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) INTERSTITIAL PNEUMONIA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 1-30-68		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) YES	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED January 27, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 1-30-68	24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cem.	24D. LOCATION (City, town, or county) (State) Anne Arundel Cty. Md.
25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968	25B. NAME OF REGISTRAR Robert E. Fairbank	25C. FUNERAL DIRECTOR ADDRESS WM MARCH 928 E. North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 68- 1126	
BIRTH NO. 68- 1126		CERTIFICATE OF DEATH			
M.E. CASE NO. H.					
1. NAME OF DECEASED (Type or Print) John Thompson		2. DATE AND HOUR OF DEATH 1-25-68 8:45 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION Simi Hospital Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 5015 Palmer Ave			
5. SEX Male	6. RACE Negro	7. <input checked="" type="checkbox"/> MARRIED, NEVER MARRIED <input type="checkbox"/> WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 1887	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sugar free long, farming		10B. KIND OF BUSINESS OR INDUSTRY Sugar Refining		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Maggie Thompson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT daughter ADDRESS 5015 Palmer Ave.	
18. 486X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Myocardial infarction (A) DUE TO Suspect.		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pneumonia (B) DUE TO (C) 3 days.					
19. DATE OF OPERATION 493X II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from 1-24 19 68 to 1-25 19 68 , that (I) <u>(we)</u> lost saw the deceased alive on 1-25 19 68 and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE Saul Kreitman		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-25-68	
23C. PHYSICIAN'S NAME (Type) GARY KREITMAN		23D. ADDRESS Simi Hospital of Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-29-68		24C. NAME OF CEMETERY or CREMATORY MA. Auburn Cem.	
		24D. LOCATION (City, town, or county) (State) BALTS, MD.			
25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968		25B. NAME OF REGISTRAR Robert E. Jankovna		25C. FUNERAL DIRECTOR WM C. MARCH ADDRESS 928 E. North Ave	



1
B-300

68-1127 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-1127

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) HARRY BOYD		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 1 27 68 1:00a M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 1417 N. Broadway		3. DATE PRONOUNCED DEAD Month Day Year Hour January 27 1968 1:00a M.	
6. SEX Male		7. RACE Colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
9. DATE OF BIRTH June 1st		10. AGE (In years last birthday) 73	
11. BIRTHPLACE (State or foreign country) Middlesex, U.K.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		15. MOTHER'S MAIDEN NAME Charlotte Homes	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, near unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 213-01-5763	
18. INFORMANT Helen Boyd		ADDRESS Same	
19. CAUSE OF DEATH 412.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive Arteriosclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 443X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) No	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Edward F. Wilson, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED January 27, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-21-68	
24C. NAME OF CEMETERY or CREMATORY Carron Memorial Park		24D. LOCATION (City, town, or county) (State) Lanre Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968		25B. NAME OF REGISTRAR R. E. J. F. J. F.	
25C. FUNERAL DIRECTOR, Charles O. Wilson		ADDRESS 1000 Bantley Ave	

THE UNIVERSITY OF CHICAGO

IN THE DEPARTMENT OF THE HISTORY OF ARTS

BY

JOHN

W. B. B. B.

CHICAGO

1910

CHICAGO

THE UNIVERSITY OF CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>68-1128</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>68-1128</u>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) FRANCIS DAVIS		2. DATE AND HOUR OF DEATH <u>1/25/68</u> <u>7:21</u> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> IN CITY LIMITS	
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u>		D. STREET ADDRESS (If rural, give location) <u>2011 E. JEFFERSON ST.</u>			
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>2-10-63</u>	9. AGE (In years last birthday) <u>4</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>CHARLES DAVIS</u>		14. MOTHER'S MAIDEN NAME <u>BARBARA GOINES</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Charles Davis</u>		ADDRESS <u>Secur</u>
18. <u>E895X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Smoke + Thermal Injury to lungs</u> <u>secondary anoxic damage to brain</u> <u>Heart + Kidneys</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 hours</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>E916.0 II</u>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <u>2</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>YES</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>6-04</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>HOME</u>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>3rd floor 2011 Jefferson St</u>	21F. HOW DID INJURY OCCUR? <u>possibly a faulty gas heater caused fire</u>		
21D. TIME OF INJURY (APPROX.) <u>1-25-68 2:13 PM</u>	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	22. I certify that (I) (this hospital) attended the deceased from <u>1/25</u> 19 <u>68</u> to <u>1/25</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1/25</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Irvin R. Cohen</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <u>1/25/68</u>		
23C. PHYSICIAN'S NAME (Type) <u>IRVIN R. COHEN</u>		23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>1-30-68</u>	24C. NAME OF CEMETERY or CREMATORY <u>Mt Auburn Cent</u>	24D. LOCATION (City, town or county) (State) <u>Baltimore</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 29 1968</u>	25B. NAME OF REGISTRAR <u>R. E. Feltner</u>	25C. FUNERAL DIRECTOR <u>Charles Davis</u>			

RECEIVED BY [illegible] 1/18/71

1/18/71
[illegible]
[illegible]
[illegible]

[illegible]

214

[illegible]

IRVING A. COHEN

1/18/71

1/18/71

X

1/18/71

FUNERAL DIRECTOR: IMPORTANT 2568

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1129

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 1129

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Miller, Odell V.		1-25-68 9:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
Johns Hopkins Hospital			1200 McElderry Ct Apt C Balt. Md		
5. SEX FEMALE			6. RACE NEGRO		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 11-18-20		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			9. AGE (In years last birthday) 48* 47		
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		
			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME JOHN ATKINS			14. MOTHER'S MAIDEN NAME SUSIE ALLEN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			17. INFORMANT ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 571.0 I HEPATIC COMA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 3 WEEKS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CIRRHOSIS - LAMNAC'S (B) DUE TO, OR AS A CONSEQUENCE OF: 6 MONTHS (C).....			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 581.1 II			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) YES			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1-9 1968 to 1-25 1968, that (I) (we) last saw the deceased alive on 1-25-68 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Major W. Bradshaw M.D.			23B. DATE SIGNED 1-25-68		
23C. PHYSICIAN'S NAME (Type) MAJOR W. BRADSHAW M.D.			23D. ADDRESS JOHNS HOPKINS HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1-31-68		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn	
24D. LOCATION (City, town, or county) (State) Baltimore		24E. NAME OF REGISTRAR Robert E. Taylor		24F. FUNERAL DIRECTOR Chung O. Wilson	
25A. DATE RECEIVED BY HEALTH DEPT. 1-25-68		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS 1000 Bunting Ave.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1130		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 1130	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JOHN E. FOSLER		January 28, 1968 1:35 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL			A. STATE MARYLAND		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 8219 BELAIR ROAD		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-02-05	9. AGE (In years last birthday) 62	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? AMERICAN		13. FATHER'S NAME CHARLES FOSLER		14. MOTHER'S MAIDEN NAME KATHERINE EMRICH	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO. 215-09-1087		17. INFORMANT Mrs. Elsie M. Fogler, 8219 Belair Rd. 36	
18. CAUSE OF DEATH					
<p>492 X I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE <u>Respiratory Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) <u>Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
327.1 II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>January 24, 1968</u> to <u>January 28, 1968</u> , that (I) (we) last saw the deceased alive on <u>January 28, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED January 28, 1968	
23C. PHYSICIAN'S NAME (Type) DR MIGUEL SANCHEZ PALSCIOUS				23D. ADDRESS UNION MEMORIAL HOSPITAL THE UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan. 31/68		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith	
24D. LOCATION Balto. Md.		24E. NAME OF REGISTRAR R. E. Farley		24F. FUNERAL DIRECTOR Philip's Herwig Sons	
25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
25D. ADDRESS 2024 Orleans St.					

A 22-2

Form 100-1

May 1948

Branch 100

UNIT MEMBER INFORMATION

8519 BELAIR ROAD

15-07-08 85

X

W

M

Electrician

MARYLAND

CHARLES FOSTER

KATHERINE EMILY

Respiratory Infection

Emphysema

January 28, 1948

W. J. [Signature]

X

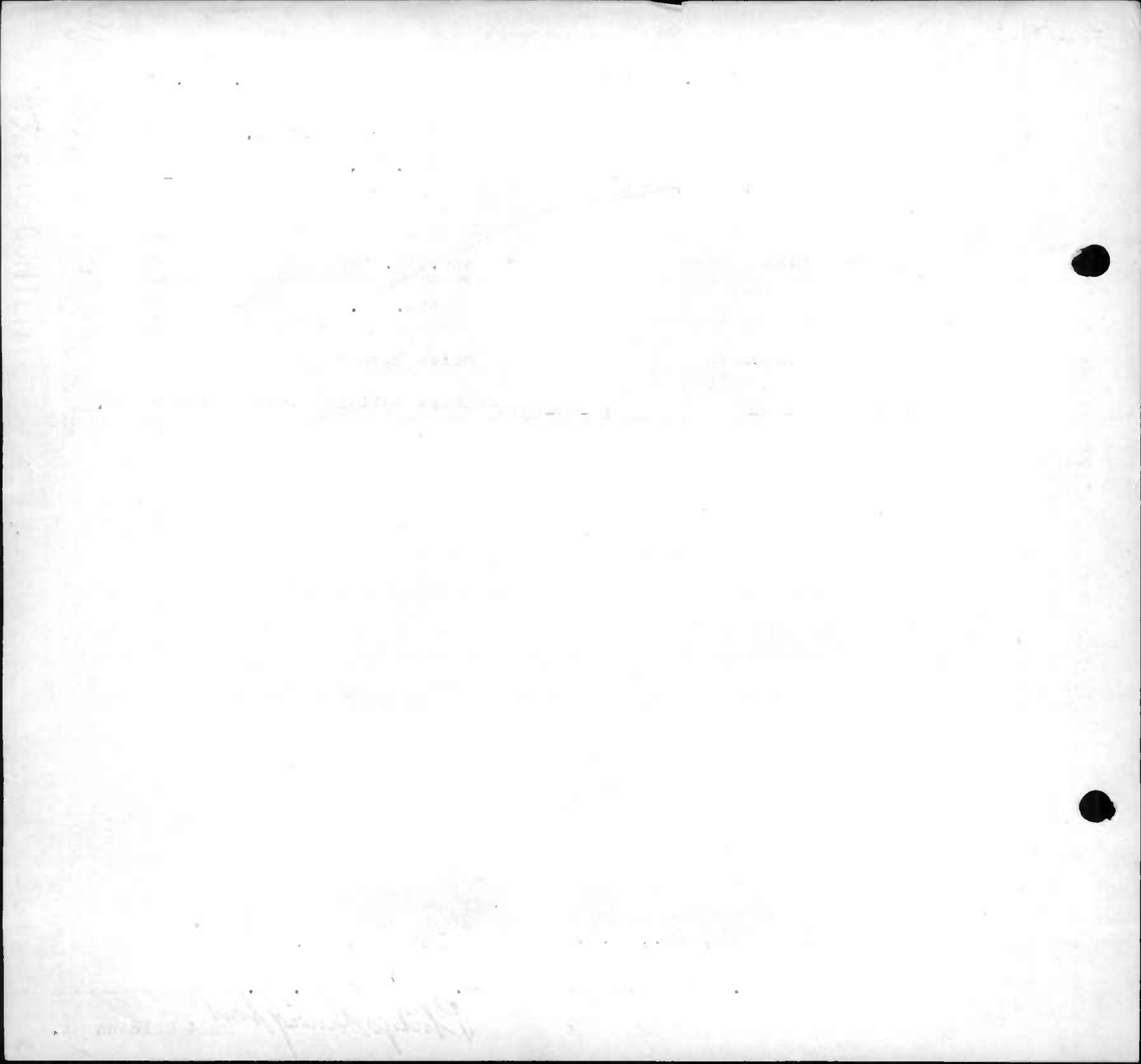
UNIT MEMBER INFORMATION

January 28, 1948

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68- 1131				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 1131	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Lottie H. Bullock				Jan. 26th. 1968			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
Johns Hopkins Hosp/				2402 McElderry St.			
C. CITY OR TOWN				D. INSIDE CITY LIMITS?			
Balto. Md.				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER							
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		Apr. 4th. 1920	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
47				Balto. Md.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John Telakowitz				Helen Hepner			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
----				213-09-5313		Charles Bullock 2402 McElderry St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				Cerebral accident			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Hypertension			
(C) -----							
19. DATE OF OPERATION				20. AUTOPSY? (Yes or No)		21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
331X II				1966		11/3/67	
22. I certify that (I) (this hospital) attended the deceased from 11/14 to 11/3/67 that (I) (we) last saw the deceased alive on 11/3/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Louis Vogel, Jr., M.D.				1/27/68			
24A. BURIAL CREMATION REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial				Jan. 30/68		Holy Redeemer Cem.	
25A. DATE REC'D BY HEALTH DEPT				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 29 1968				Robert E. Taylor		2024 Orleans St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1132

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-1132

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Carl J. Staudenmayer		2. DATE AND HOUR OF DEATH January 27, 1968		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Belvedere House in the Pines				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 18 Summerfield Road			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-19-1896	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic - Glen L. Martin			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
13. FATHER'S NAME Charles F. Staudenmayer			14. MOTHER'S MAIDEN NAME Weber		12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-01-3206		17. INFORMANT Freda Roig -4401 Roland Avenue			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 433.9 I Cerebral THROMBOSIS (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 332 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic Rheumatoid Arthritis.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) this hospital attended the deceased from September 1964 to January 27, 1968 , that (I) we last saw the deceased alive on January 26, 1968 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) we did (did not) view the body after death.							
23A. SIGNATURE Fern Osلمان M.D.				23B. DATE SIGNED 1-27-68		23C. PHYSICIAN'S NAME (Type)	
23D. ADDRESS 5907 Angwyn Oak Ave 21207				DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-30-68		24C. NAME OF CEMETERY or CREMATORY Western Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Ellsworth Armacost -4600 Liberty Hghts. Ave			

1000-1000

1000-1000

1000-1000

1000-1000

1000-1000

1000-1000

1000-1000

1000-1000

1000-1000

1000-1000

1000-1000

1000-1000

1000-1000

1000-1000

1000-1000

1000-1000

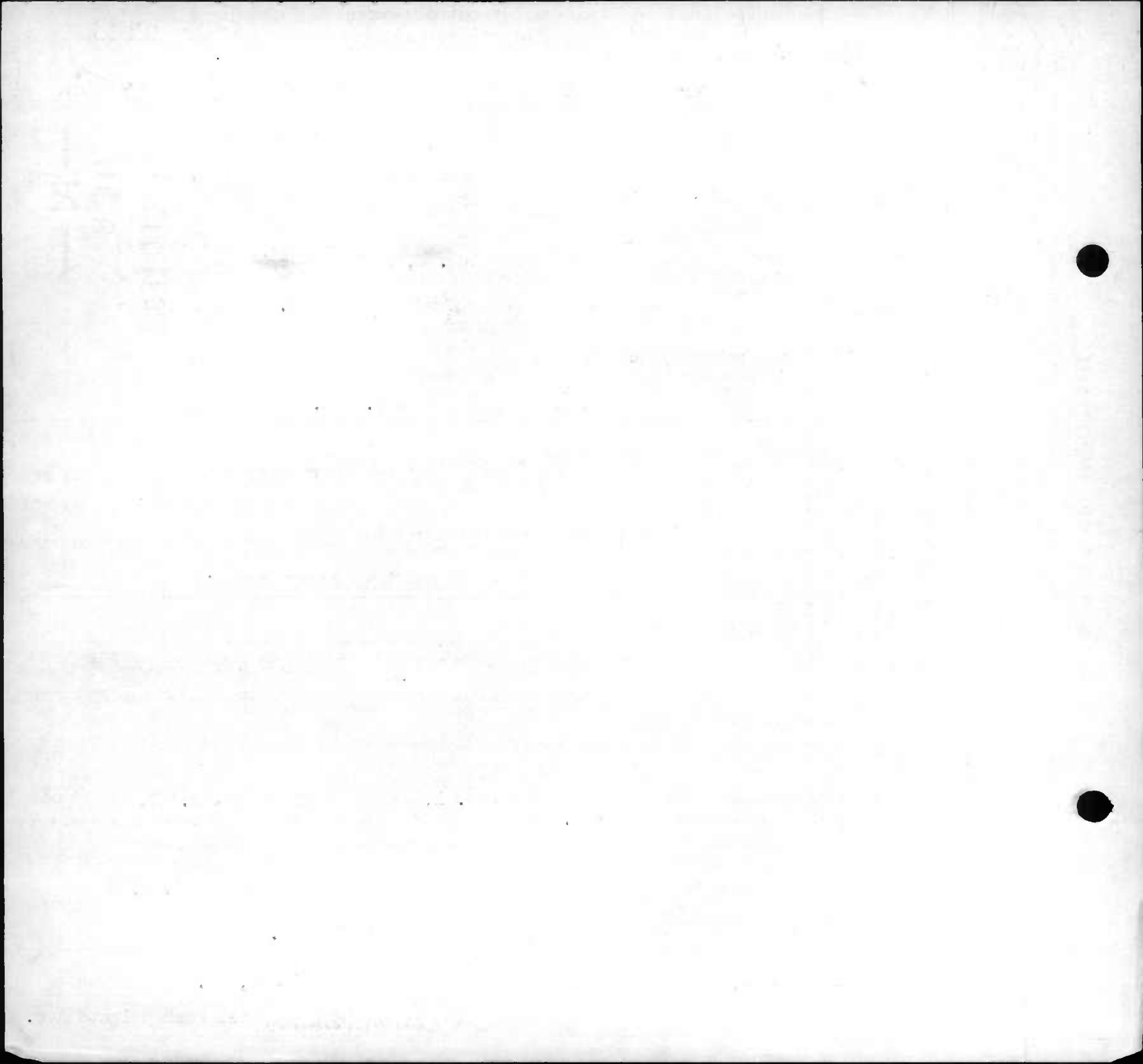
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-1133

BIRTH NO. 68-1133		BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type or Print) MARY MUFFOLLETTA		2. DATE AND HOUR OF DEATH 1/27/68 2:37 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI Hosp OF BALTIMORE		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5303 Hamlin Ave.	
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 8, 1891
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY At Home	9. AGE (In years lost birthday) 76
11. BIRTHPLACE (State or foreign country) BALTIMORE Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME (First name unknown) Meehan		14. MOTHER'S MAIDEN NAME unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Hosp. Rec.
18. 427.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIO-PULMONARY ARREST ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) HYPOTENSION, ACUTE (C) CHRONIC CONGESTIVE HEART FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 434.1 II			
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan. 1, 1968 to Jan. 27, 1968 , that (I) (we) lost saw the deceased alive on Jan. 27, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Thomas P. Smith MD		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED 1/27/68
23C. PHYSICIAN'S NAME (Type) THOMAS P. Smith		23D. ADDRESS Sinai Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 1/31/68	24C. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968		25B. NAME OF REGISTRAR Robert E. Fairman	25C. FUNERAL DIRECTOR B. Vernon Gemmon
		ADDRESS 4611 Park Heights Ave.	



1
C-130

68- 1134 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 1134

BIRTH NO.

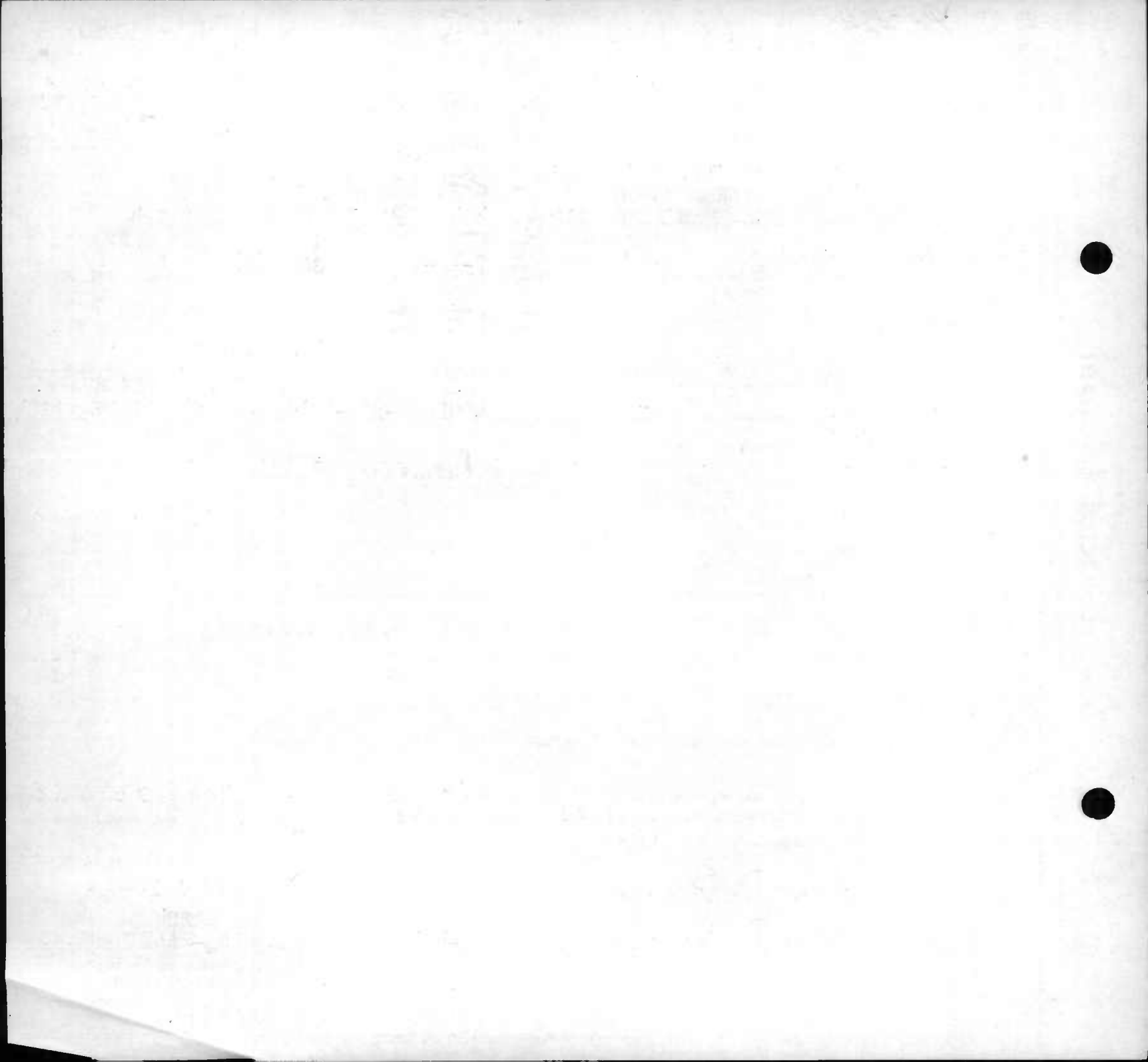
1. NAME OF DECEASED (Type or Print) CLYDE CUPITT		2. DATE Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 1 28 68 6:05 a M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 1015 Aisquith St. (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD January 28, 1968 6:05 a M.	
6. SEX Male		7. RACE Colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 10-01	
9. DATE OF BIRTH 5/29/17		10. AGE (In years last birthday) 50	
11. BIRTHPLACE (State or foreign country) VA		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Cupitt		14. MOTHER'S MAIDEN NAME Roxy Davis	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		16. KIND OF BUSINESS OR INDUSTRY AUTOMATIC ROLLS	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 10/14/43 - 2-14-45		18. SOCIAL SECURITY NO. 2803 2494	
19. CAUSE OF DEATH 412.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2/		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED January 28, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/31/68	
24C. NAME OF CEMETERY or CREMATORY BALTO. National		24D. LOCATION (City, town, or county) (State) 5501 Frederick Ave	
25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968		25B. NAME OF REGISTRAR Robert E. Fisk	
25C. FUNERAL DIRECTOR Joseph J. Locks Jr.		ADDRESS 1304 N. Central	

35-53-23 1B

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-256 68-1135				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1135	
BIRTH NO. 7-16-83				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) CLARA W. BECKMYERS Clara Beckmeyer				2. DATE AND HOUR OF DEATH 1-26-68 13:15 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 4940 EASTERN AVENUE-21224							
5. SEX Female		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-16-83	
9. AGE (In years last birthday) 84		10. AGE (In years last birthday) 84		11. BIRTHPLACE (State or foreign country) MARYLAND, Baltimore		12. CITIZEN OF WHAT COUNTRY? UUSA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Adam Wiener				14. MOTHER'S MAIDEN NAME Caroline Younger			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 215 54 1584		17. INFORMANT C. Raymond Knipp 2523 Hamilton Ave. RECORDS-BCH-4940 EASTERN AVENUE-21224	
18. 011.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE Pulmonary T.B. DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
19. 002.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Generalized arteriosclerosis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 21		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Oct. 3 19 62 to Jan. 26 19 68, that (I) (we) last saw the deceased alive on 1-26 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ross T. Krueger				23B. DATE SIGNED 1-26-68		23C. PHYSICIAN'S NAME (Type) Ross T. Krueger	
23D. ADDRESS BCH-4940 EASTERN AVENUE-BALTIMORE, MD 21224							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/27/68		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Henry Sander & Sons Inc. Baltimore Maryland 21213		25D. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1136
5-356		68-1136		CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) stiner, frederic M		
		2. DATE AND HOUR OF DEATH 1/27/68 6:45 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		C. CITY OR TOWN BALTO. 21201		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 232 W. LAFAYETTE AVE		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/21/14	9. AGE (In years last birthday) 53
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vis. Info. Spec		10B. KIND OF BUSINESS OR INDUSTRY Medical School		11. BIRTHPLACE (State or foreign country) Rochester N.Y.
12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Frederic Martin Stiner		14. MOTHER'S MAIDEN NAME Marie Elizabeth Maney		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1942 To 1946 WW#2 071-18-2083		16. SOCIAL SECURITY NO. 232 West Lafayette Avenue		
17. INFORMANT Mrs Bertha Moulton Stiner		ADDRESS		
18. 4/10/9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II				
21A. DATE OF OPERATION 2/1		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 1/27/68 19 68 to 1/27/68 19 68 , that (I) (we) last saw the deceased alive on 1/27 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Gary M. Latten M.D.				23B. DATE SIGNED 1/27/68
23C. PHYSICIAN'S NAME (Type) GARY M. LATTIN				23D. ADDRESS University Hospital
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/31/68		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery
24D. LOCATION (City, town, or county) Baltimore Maryland				
25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968		25B. NAME OF REGISTRAR Robert E. Falek		25C. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS INC. BALTIMORE, MARYLAND 21213

University of Toronto
M. S.
No. 240. 240

Prof. M. S. S.
University of Toronto

1

E-400

P-400

68-1137

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-1137

BIRTH NO.

1. NAME OF DECEASED (Type or Print) NATHANIEL POWELL EL		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> January 26, 1968 7:15 A M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 813 North Mount Street		3. DATE PRONOUNCED DEAD Month Day Year Hour January 26, 1968 7:15 A M.	
6. SEX Male	7. RACE Negro	5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 16-03	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH	10. AGE (In years, months, days, hours, minutes) 70	E. STREET AND NUMBER 813 N Mount St	
11. BIRTHPLACE (State or foreign country) CAMILLA GA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Honny Powell		14. MOTHER'S MAIDEN NAME Mary	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET LABORER		14B. KIND OF BUSINESS OR INDUSTRY GEN REFRAC TORES	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.	
18. INFORMANT PEARL POWELL #1 813 N Mount St		ADDRESS	
19. 412.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) DATE SIGNED 1-26-68 ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR		ADDRESS	

T-460

68-1138 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-1138

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ROBERT TAYLOR JR.

2. DATE

Known ☐ Estimated ☒

Month

Day

Year

Hour

DEATH

1

28

68

10:20 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 Harbor-1700 Pen Hill Ave.

3. DATE

Month

Day

Year

Hour

PRONOUNCED DEAD

January

28

68

10:20 a.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Balto

D. INSIDE CITY LIMITS

YES ☒NO ☐

6. SEX

Male

7. RACE

Colored

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

3-8-1914

10. AGE (In years
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

2910 Spring Hill Ave. Springhill

11. BIRTHPLACE (State or foreign country)

BALTO MD

12. CITIZEN OF

U.S.A.

13. FATHER'S NAME

Robert Taylor

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

CRANE OPERATOR

14B. KIND OF BUSINESS OR INDUSTRY

BOSTON METALS

15. MOTHER'S MAIDEN NAME

UNKNOWN

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL SECURITY NO.

18. INFORMANT

Laugano Taylor 3444 Pk. Heights Ave

ADDRESS

E 836 X B

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Multiple Injuries
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

MEDICAL CERTIFICATION

E 836 X

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about

home, farm, factory, street, office bldg., etc.)

Water (Boat)

22C. WHERE DID (If in Baltimore City, give exact location)

INJURY OCCUR?

Ft. of 1700 Pen Hill Ave.--Curtis Bay

22D. TIME (Month) (Day) (Year) (Hour)

OF INJURY

(APPROX.)

1

25

68

9:30a

22E. INJURY OCCURRED

WHILE AT

WORK ☒

NOT WHILE

AT WORK ☐

22F. HOW DID INJURY OCCUR?

Subject was operating a crane, crane

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐broke loose and went into
water

ACTUAL

SIGNATURE

EXAMINER'S

NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 28, 1968

24A. BURIAL CREMATION,

REMOVAL (Specify)

Burial

24B. DATE

2/1/68

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn

24D. LOCATION

(City, town, or county)

BALTO MD

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 29 1968

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Mansuet P. Hayes 638 n Gilmor St

ADDRESS

3-8-1941

Barro m

Robert Taylor

James Stewart

no

James Stewart

Robert m

James Stewart

James Stewart

James Stewart

I-645

68-1139 BALTIMORE CITY HEALTH DEPARTMENT

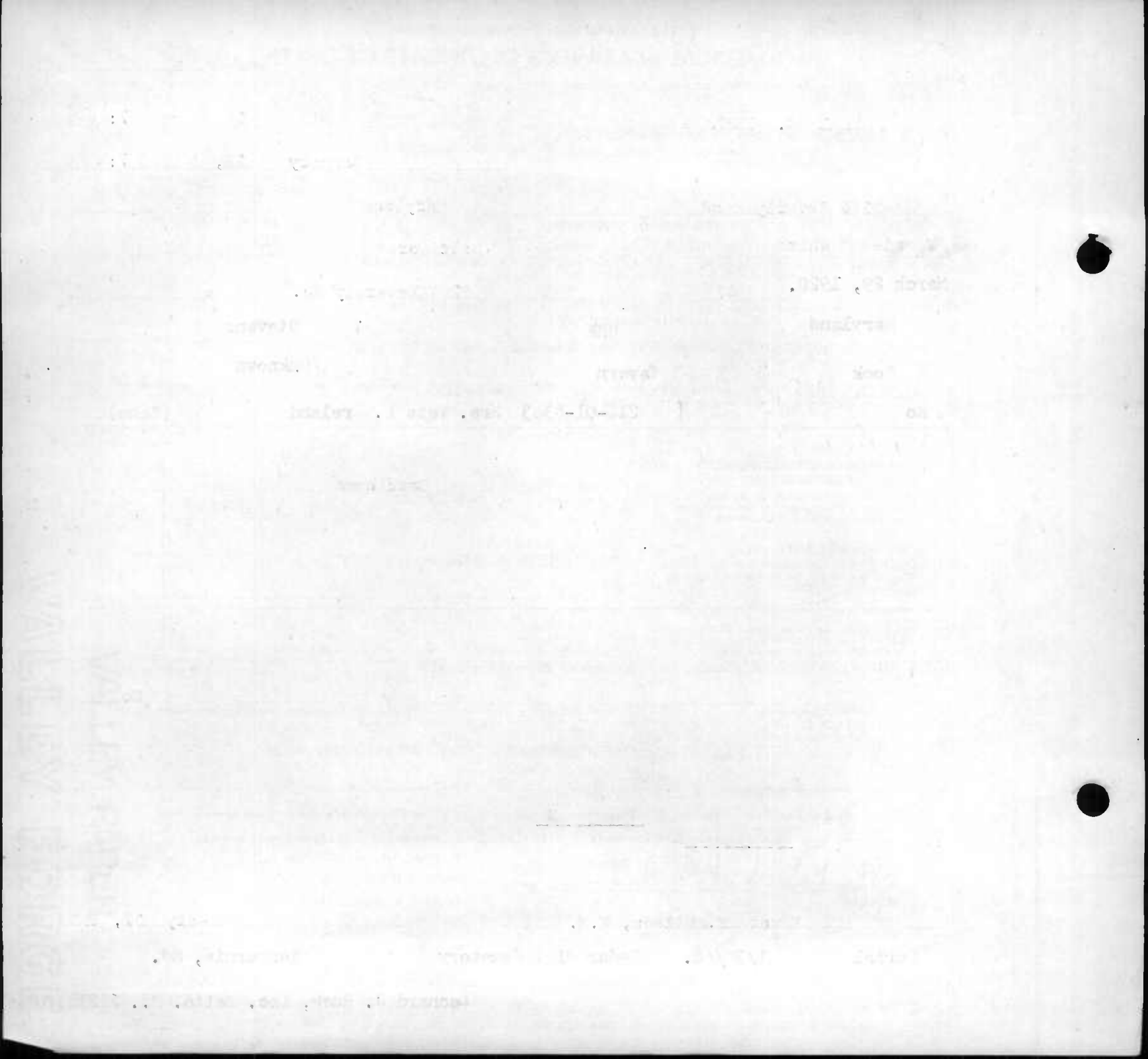
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-1139

REG. NO.

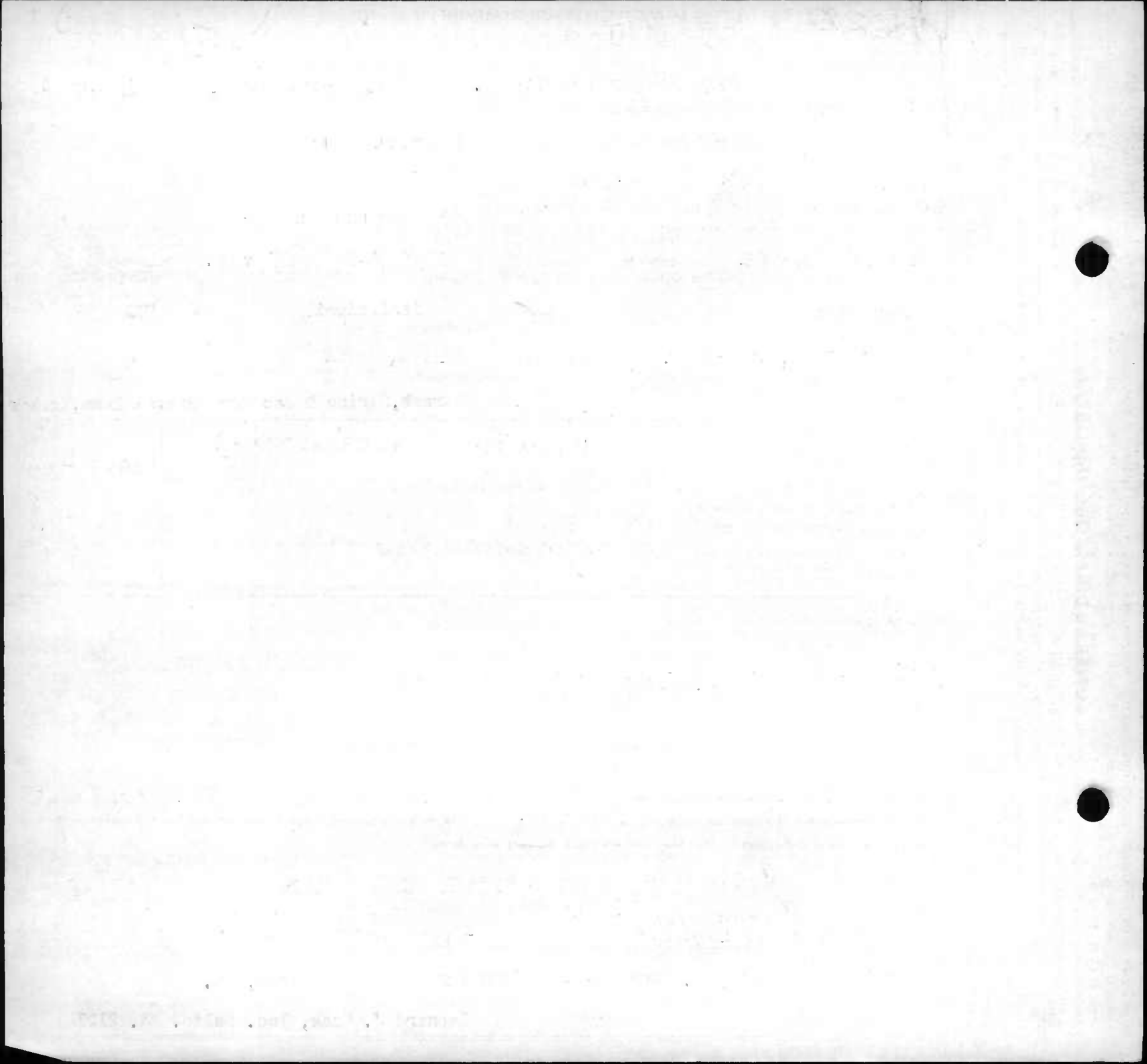
BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY C. IRELAND		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 26 68 7:40 p. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 3205 Beverly Road (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour January 26, 1968 7:40 p. M.	
6. SEX Female		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 21-01	
9. DATE OF BIRTH March 29, 1920.		10. AGE (In years lost birthday) 47	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		14B. KIND OF BUSINESS OR INDUSTRY Tavern	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 214-01-8343	
15. MOTHER'S MAIDEN NAME Unknown		18. INFORMANT Mrs. Veta L. Ireland	
19. 199.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Carcinoma DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 199.2 II		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 199.2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED January 27, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/30/68.	
24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) Glenburnie, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-620		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	68-1140
BIRTH NO.		68-1140		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		BROOKS, ELIZABETH J.		2. DATE AND HOUR OF DEATH JAN. 27, 1968. 4:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		V-35	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		PENNSYLVANIA		C. CITY OR TOWN YORK	
THE JOHNS HOPKINS HOSPITAL, 601 N. BROADWAY, BALTIMORE, MD-21205		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 157 SPRINGDALE ROAD	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/18/00	9. AGE (In years lost birthday) 67 YRS.	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Mississippi	
13. FATHER'S NAME JOHNSON, JAMES H.		14. MOTHER'S MAIDEN NAME SHAW, ONEY		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 199 14 2370		17. INFORMANT ADDRESS Strack, Strine & Jackson Funeral Home, York Pa	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH BRAIN TUMOR (GLIOBLASTOMA). (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ABOUT 4 months	
MEDICAL CERTIFICATION 193.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION JAN. 24, 1968		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BRAIN TUMOR - GLIOBLASTOMA.	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from JAN. 22, 1968 to JAN. 27, 1968, that (I) (we) last saw the deceased alive on JAN. 27, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. Bhushan M.D., B.S., L.M.C.E.		23B. DATE SIGNED 1/27/68		23C. PHYSICIAN'S NAME (Type) CHHABI BHUSHAN M.D., B.S., L.M.C.E.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/29/68		24C. NAME OF CEMETERY or CREMATORY Prospect Hill Cemetery	
24D. LOCATION York, Pa.		24E. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		24F. ADDRESS THE JOHNS HOPKINS HOSPITAL, BALTIMORE, MARYLAND 21205	
25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

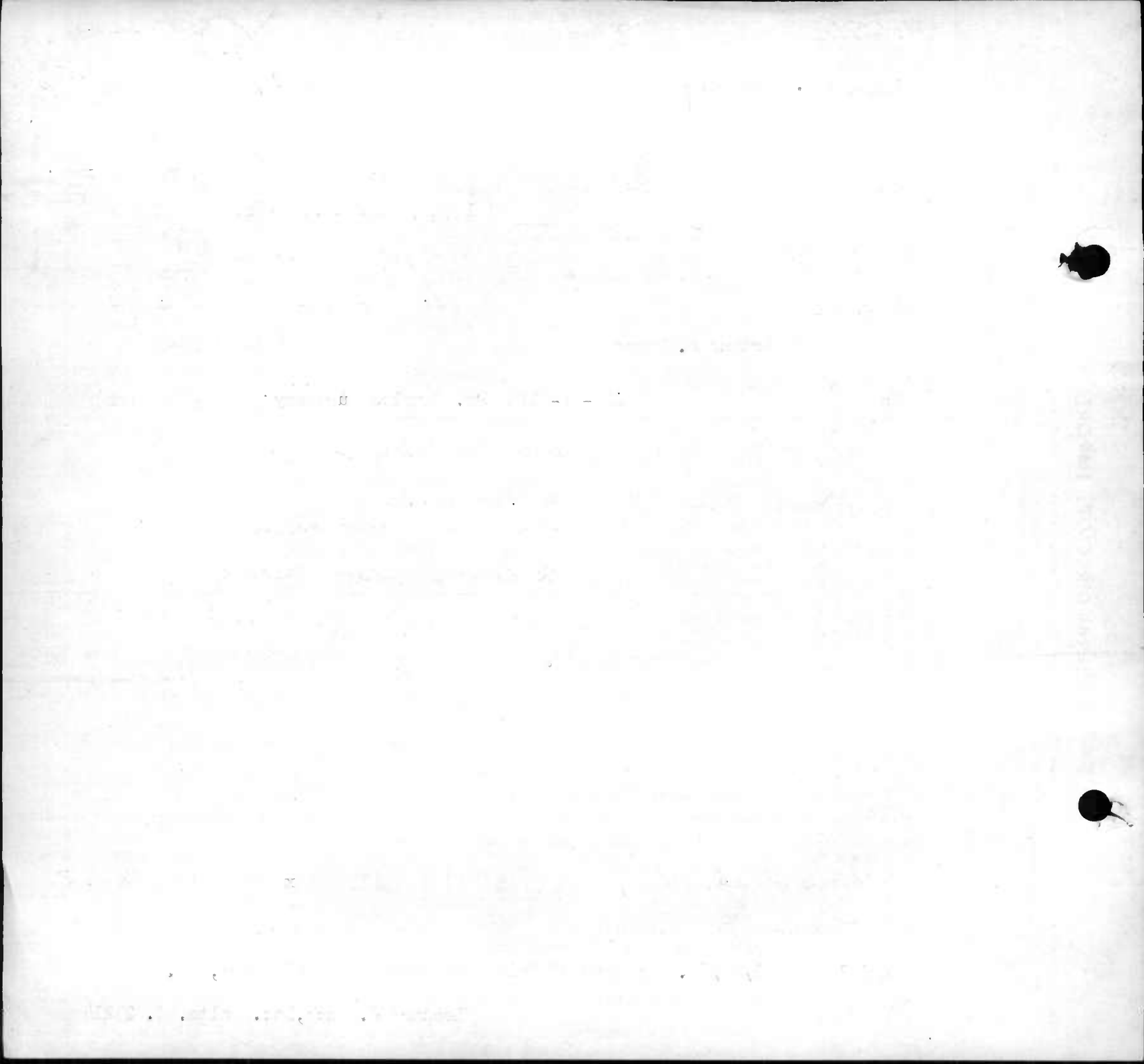
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-160		68-1141		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1141	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Pifer, George C.</i>				2. DATE AND HOUR OF DEATH <i>1/26/1968 11 45 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Union Memorial Hosp.</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>12-066</i>			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>M</i>		6. RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4/10/94</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Steel Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Penna.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Alvin Henry Pifer</i>				14. MOTHER'S MAIDEN NAME <i>Tamazine Gardner</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>188-14-3670</i>		17. INFORMANT <i>Helen M. Lindley</i>		ADDRESS <i>(Same)</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>430.9 I Subarachnoid Hemorrhage</i> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>330X II</i>				CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Termination</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>med</i> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 hours</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>1/20/68</i> to <i>1/26/68</i> , that (I) (we) last saw the deceased alive on <i>1/20/68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>H. F. Holcomb, Jr.</i>				23B. DATE SIGNED <i>1/26/1968</i>			
23C. PHYSICIAN'S NAME (Type) <i>DR. HARRY F. HOLCOMB, JR.</i>				23D. ADDRESS <i>THE UNION MEMORIAL HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/30/68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Union Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Bellefonte, Pa.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 29 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairbank</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc.</i>		ADDRESS <i>Balto. Md. 21214</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

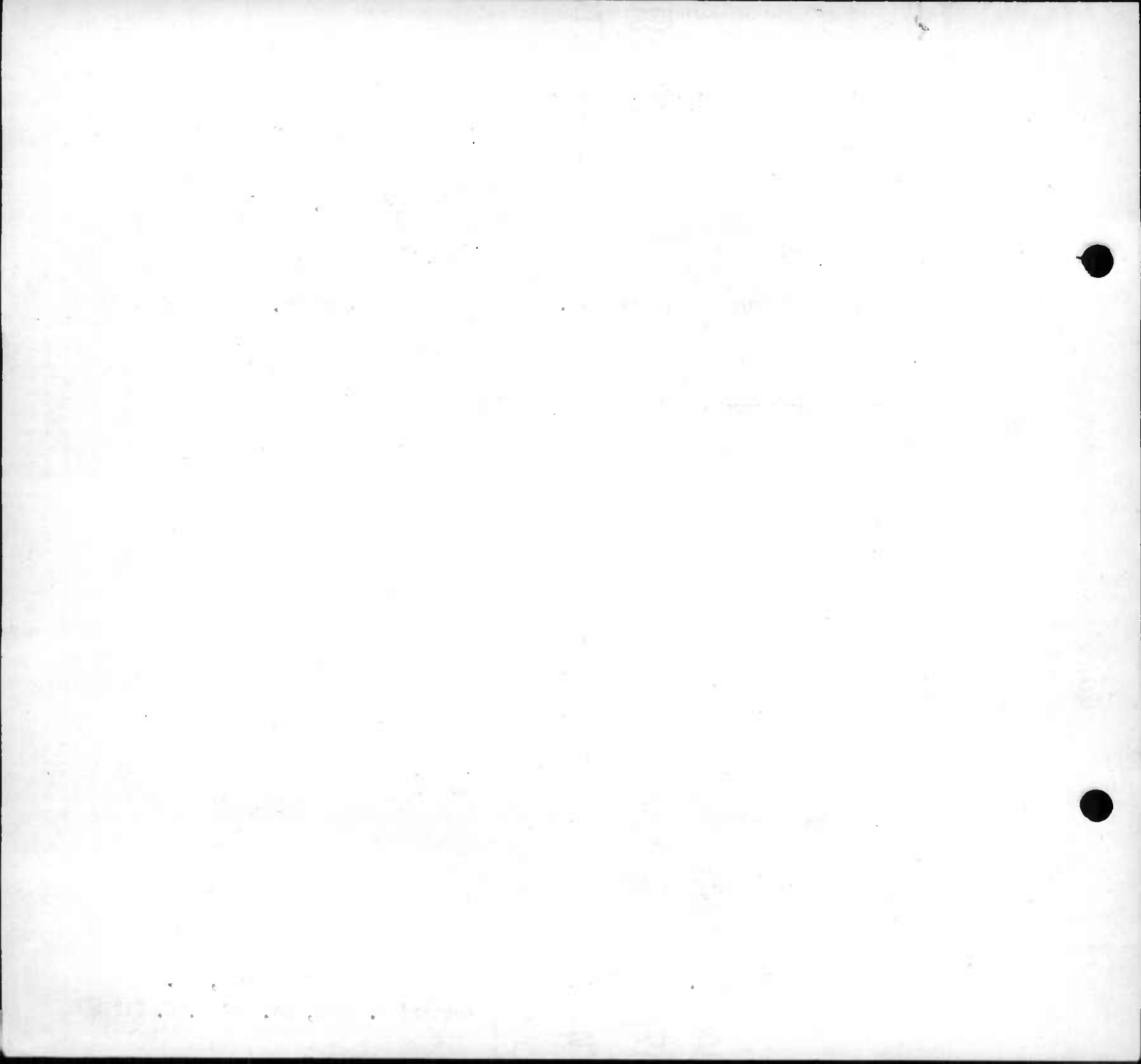
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1142	
M-652 68-1142 CERTIFICATE OF DEATH					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <u>LUCILLE R. MURANSKY</u>			2. DATE AND HOUR OF DEATH <u>1/27/68</u> <u>10 45</u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL OF BALTIMORE</u> <u>42</u>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10B. KIND OF BUSINESS OR INDUSTRY		E. STREET AND NUMBER <u>1749 WEYBURN RD.</u>
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/29/19</u>	9. AGE (In years last birthday) <u>48</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
11A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			11B. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Arthur A. Pryor</u>			14. MOTHER'S MAIDEN NAME <u>Ella Saunders</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>229-14-0173</u>		17. INFORMANT <u>Mr. Charles Muransky</u>
			ADDRESS <u>(Same)</u>		
18. <u>398X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>CARDIO-PULMONARY ARREST</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>416X</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>NO ENDOCARDITIS</u> (B) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>RHEUMATIC HEART DISEASE</u>		
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Thomas P. Smith</u>			Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1/28/68</u>
23C. PHYSICIAN'S NAME (Type) <u>Thomas P. Smith</u>			23D. ADDRESS <u>SINAI HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/31/68</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 29 1968</u>			25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

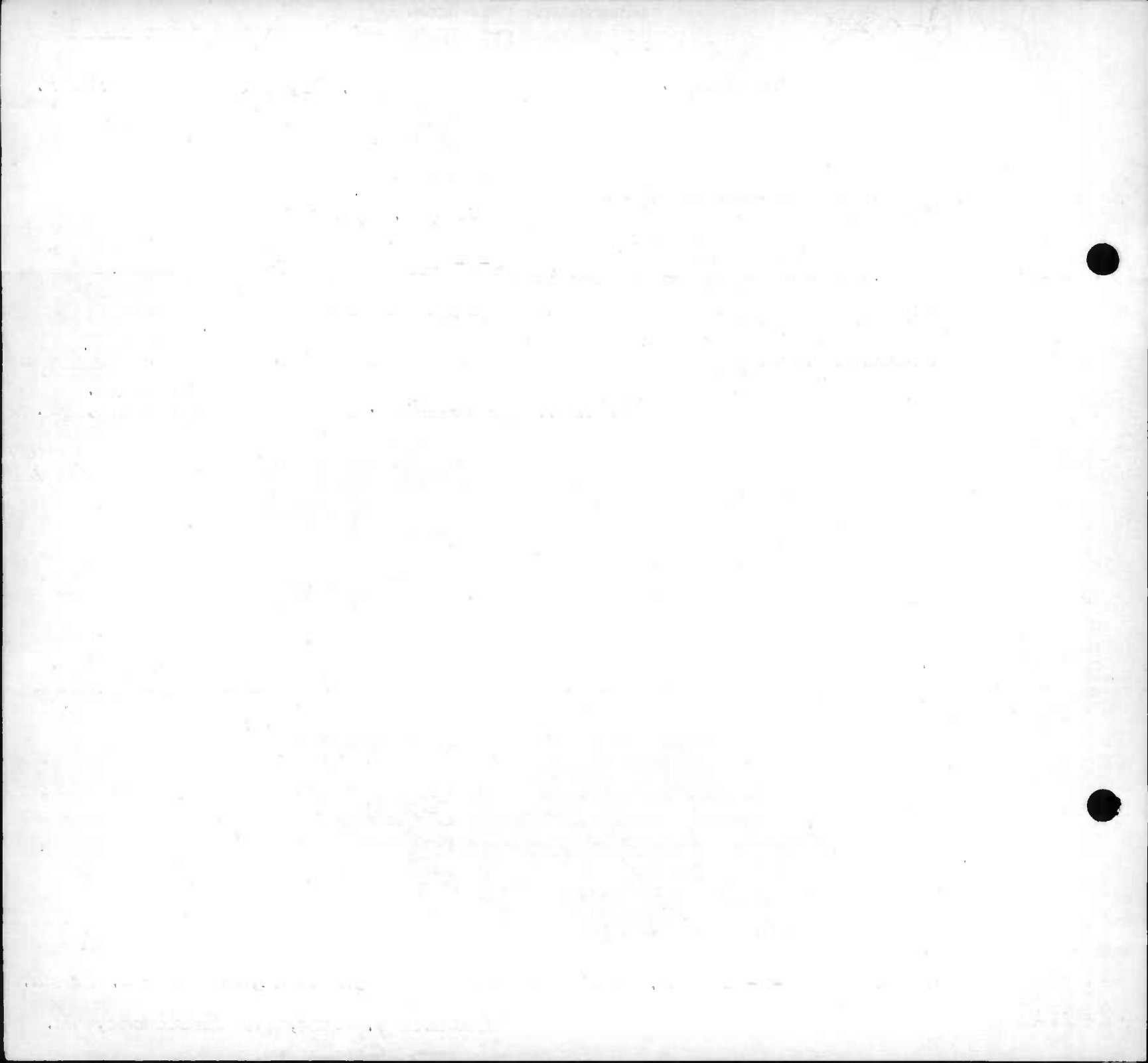
BALTIMORE CITY HEALTH DEPARTMENT		68-1143		CERTIFICATE OF DEATH		REG. NO. 68-1143	
BIRTH NO. <u>M-625</u>				1. NAME OF DECEASED (Type or Print) <u>Richard J. Morgenweck, Jr.</u>			
2. DATE AND HOUR OF DEATH <u>11/27/68</u> <u>9:35 PM</u> M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO.</u>				5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
C. CITY OR TOWN <u>BALTO.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				E. STREET AND NUMBER <u>5818 Royal Oak Ave</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Telephone Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard G. Morgenweck</u>				14. MOTHER'S MAIDEN NAME <u>Mary Nordhause</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW I</u>				16. SOCIAL SECURITY NO. <u>22-05-0586A</u>		17. INFORMANT <u>Hosp. Chert</u>	
18. <u>162.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Metastatic Carcinoma of Lung</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____							
19. DATE OF OPERATION <u>11/26/68</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Spinal Cord Tumor</u>				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/28/68</u> 19 to <u>11/27/68</u> 19, that (I) (we) last saw the deceased alive on <u>11/27/68</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Jeffrey Stier, MD</u>				23B. DATE SIGNED <u>11/27/68</u>		23C. PHYSICIAN'S NAME (Type) <u>JEFFREY STIER, MD</u>	
23D. ADDRESS <u>MD. Gen Hosp</u>				23E. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>		23F. ADDRESS <u>BALTO. MD.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/31/68.</u>		24C. NAME OF CEMETERY or CREMATORY <u>Woodlawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 29 1968</u>				25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

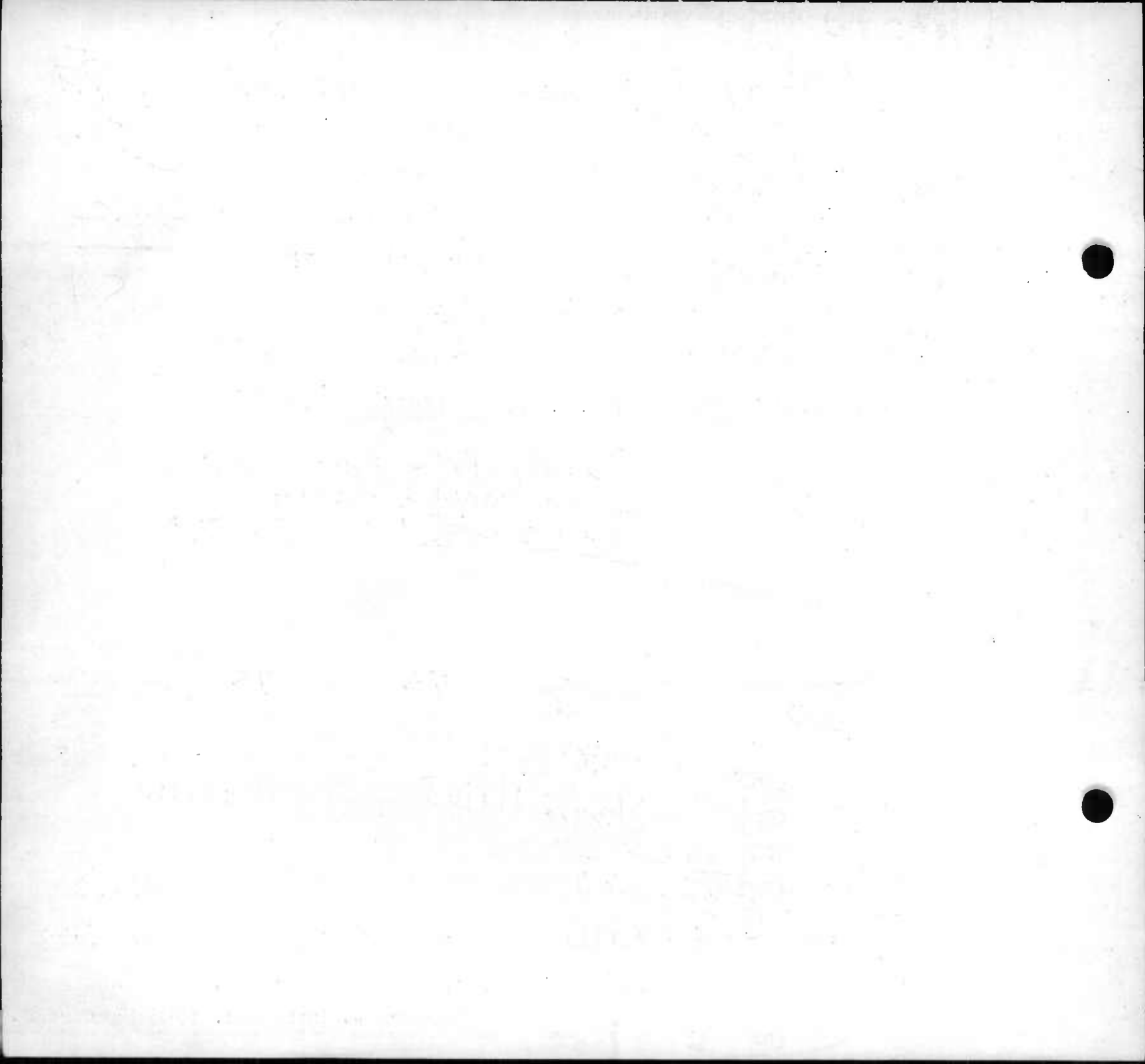
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1144
G-620 68-1144 CERTIFICATE OF DEATH		1		
1. NAME OF DECEASED (Type or Print) Loretta C. Gross		2. DATE AND HOUR OF DEATH Jan. 28, 1968 1:20 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Colorado B. COUNTY V-05		
5. SEX female		6. RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 8-8-1897		9. AGE (In years last birthday) 70		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Theobald Wackley		
14. MOTHER'S MAIDEN NAME Mary Sharp		15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. 214245097		17. INFORMANT William A. Gross		
18. ADDRESS 2016 Swansee Rd. Baltimore, Md.		19. CAUSE OF DEATH		
19A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		19B. IMMEDIATE CAUSE Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: 19C. DUE TO, OR AS A CONSEQUENCE OF: Diabetes Scurvy		
20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Dec 25, 1967 to Jan 28, 1968		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		
22. DATE OF OPERATION 260X		23. CONDITION FOR WHICH OPERATION WAS PERFORMED		
24. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		27. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
28. DATE OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		29. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
30. HOW DID INJURY OCCUR?		31. I certify that (I) (this hospital) attended the deceased from Dec 25, 1967 to Jan 28, 1968 , that (I) (we) last saw the deceased alive on Jan 18, 1968 and that in (my) (our) opinion death occurred on the date Jan 28, 1968 and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
32. SIGNATURE Franklin E. Leslie		33. DATE SIGNED 1/29/68		
34. PHYSICIAN'S NAME (Type) Franklin E. Leslie		35. ADDRESS 302 E 33rd. Baltimore, Md. 21218		
36. BURIAL CREMATION, REMOVAL (Specify) Burial		37. DATE 2-1-68		
38. NAME OF CEMETERY or CREMATORY St. Ann's Cemetery		39. LOCATION (City, town, or county) (State) Freeland, Luzerne Co. Penna.		
40. DATE REC'D BY HEALTH DEPT. JAN 29 1968		41. NAME OF REGISTRAR Robert E. Taylor		
42. FUNERAL DIRECTOR Leonard J. Ruck, Inc		43. ADDRESS Baltimore, Md.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

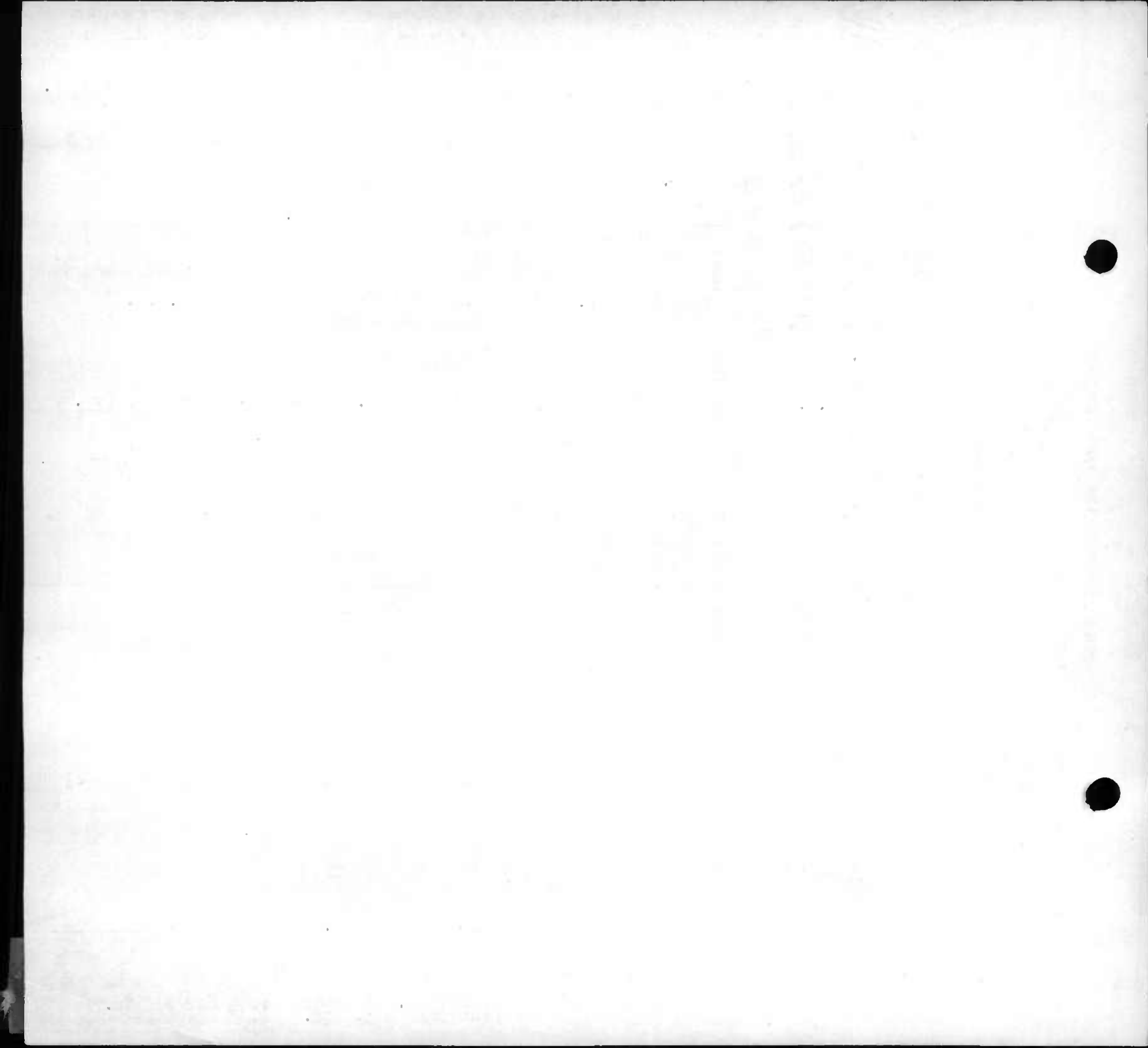
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1145	
<div style="display: flex; justify-content: space-between;"> K-220 68-1145 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Anthony R. Kucic			
2. DATE AND HOUR OF DEATH 1/28/68 7:05 PM					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTO.			
FULL NAME OF HOSPITAL OR INSTITUTION 48 Md. General Balto. Md.		C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 2336 Hamilton Circle					
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/10/21	9. AGE (In years lost birthday) 46	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10B. KIND OF BUSINESS OR INDUSTRY Machine Shop		11. BIRTHPLACE (State or foreign country) Penna	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Anthony Kucio		14. MOTHER'S MAIDEN NAME Mary Harvet			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. XXXXXXXXXX 17-16-0453		17. INFORMANT Hosp. Chart	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 753.11 WW II		CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Polycystic Kidney Disease (A) PULMONARY EDEMA End Stage Renal Disease			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/19/68 to 1/28/68 and that (I) (we) last saw the deceased alive on 1/28/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Jeffrey S. Stead MD		23B. DATE SIGNED 1/28/68		23C. PHYSICIAN'S NAME (Type) JEFFREY S. STEAD MD	
23D. ADDRESS Md. Gen Hosp. Balto. Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/1/68		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery, Baltimore Co., Maryland	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968		25B. NAME OF REGISTRAR Robert E. Fickens		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-120				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1146	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) VICTOR IRVIN DAVIS				1/25/68 11:45 p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2908 Fleetwood Ave.				A. STATE Maryland		B. COUNTY	
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2908 Fleetwood Ave.			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/11/18	9. AGE (In years last birthday) 49	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Veterans Adm.		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elmer R. Davis				14. MOTHER'S MAIDEN NAME Ella Stoner			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. W.W. II 162-12-6537		17. INFORMANT ADDRESS Josephine S. Davis 2908 Fleetwood Ave.			
18. 4129 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury at complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH Coronary Heart Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Heart Disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 yrs.	
19. DATE OF OPERATION 420.1 II				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/16 19 67 to 1/25 19 68 , that (I) (we) lost saw the deceased alive on 10/16 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Nathan Janney				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/26/68	
23C. PHYSICIAN'S NAME (Type) Nathan Janney				23D. ADDRESS 7101 Harford Rd.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/29/68		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968		25B. NAME OF REGISTRAR Robert E. Janney		25C. FUNERAL DIRECTOR ADDRESS Robert C. Altenburg 6009 Harford Rd. Funeral Home, Inc.			

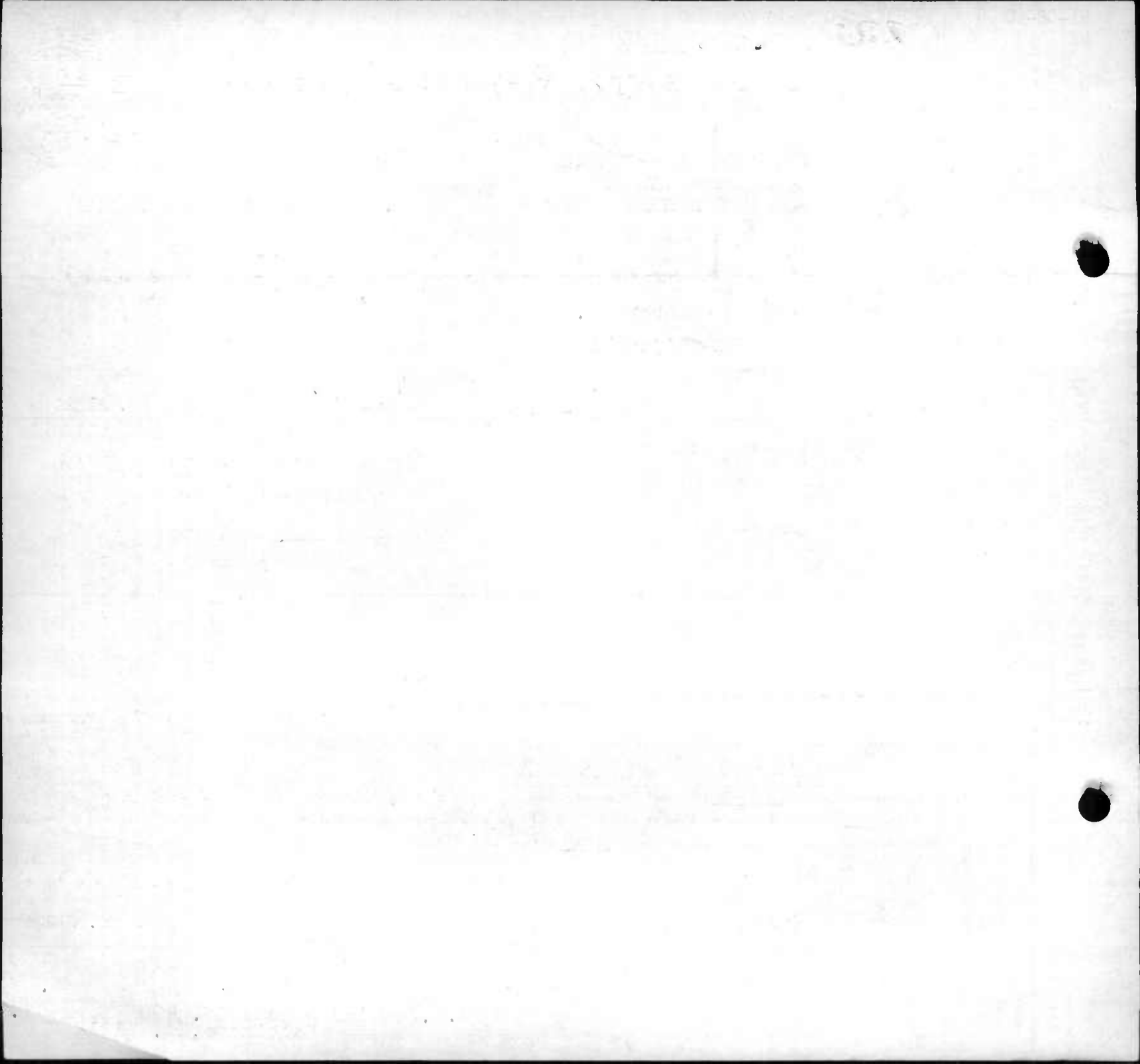


51-03-60
ME

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1147	
L-220 68-1147				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		LITIEWSKI, RAYMONDS		1/28/68 3 30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE MARYLAND 21224				A. STATE MARYLAND	
31				C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 83 RT. 2 BOX 66F FALLSTON MD. 21047	
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 8-28-24		9. AGE (In years last birthday) 43		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Foreman		10B. KIND OF BUSINESS OR INDUSTRY Rubber Co.		11. BIRTHPLACE (State or foreign country) MARYLAND, Baltimore	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME STEPHEN Lijewski		14. MOTHER'S MAIDEN NAME ROSALIE Rybarczyk	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 218-14-3906		17. INFORMANT ADDRESS RECORDS: BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MD. 21224	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 90% Total Body Thermal Burn. 24 hrs. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. E916.3 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED — 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? — 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Roller Rubber Co. 10309 Baltimore City 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Roller Rubber Co. 10309 Baltimore City 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 1/27/68 4:27 P.M. 21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? alone, painting inside of door of chemical (train) applying paint 22. I certify that (I) (this hospital) attended the deceased from 1/27/68 to 1/28/68 and that (I) (we) last saw the deceased alive on 1/28/1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE Pablo Trefogli MD 23B. DATE SIGNED 1/28/68 23C. PHYSICIAN'S NAME (Type) PABLO TREFOGGI 23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE MD. 21224 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 1/31/68 24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith 24D. LOCATION (City, town, or county) (State) Baltimore, Md. 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968 25B. NAME OF REGISTRAR Robert E. Farber 25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore, Md. 21212					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1148
1. NAME OF DECEASED (Type or Print) Robert James Taylor, Jr.		2. DATE AND HOUR OF DEATH 1-27-68 4:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 11-01		5. SEX M 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 2-25-15 9. AGE (In years last birthday) 53 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Drug Clerk 10B. KIND OF BUSINESS OR INDUSTRY Westview Drugstore 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Robert James TAYLOR		14. MOTHER'S MAIDEN NAME Helen Stinson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-01-5337 17. INFORMANT Mrs. F.W. Waightson ADDRESS 110 W. 39th St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 238.1 I PULMONARY EDEMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CEREBRAL EDEMA 237X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 237X II		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 1/20 1968 to 1/27 1968, that (I) (last saw the deceased alive on 1/27 1968 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death. 23A. SIGNATURE C. S. DeFelice Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> 23B. DATE SIGNED 1/28/68 23C. PHYSICIAN'S NAME (Type) C. S. DeFelice 23D. ADDRESS Maryland General Hospital 24A. BURIAL CREMATION, REMOVAL (Specify) Cremation 24B. DATE 1/30/68 24C. NAME OF CEMETERY or CREMATORY Greenmount 24D. LOCATION (City, town, or county) (State) Baltimore Md. 25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968 25B. NAME OF REGISTRAR Robert E. Taylor, Jr. 25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. ADDRESS 4905 York Rd Balto. 12, Md.		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1149

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 1149

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOHN A. ANDERSON

2. DATE AND HOUR OF DEATH

SUN JAN-28-1968-5:20 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

E. STREET AND NUMBER

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

508 ANNABEL AVE 21225

MARYLAND 25-04

BALTIMORE 21225 YES ☒ NO ☐

508 ANNABEL AVE

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

APR-29-1881

9. AGE (In years last birthday)

86

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Ret. Clerk

10B. KIND OF BUSINESS OR INDUSTRY

MD. STATE OFFICES

11. BIRTHPLACE (State or foreign country)

WASHINGTON, D.C.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

OLIVER P. ANDERSON

14. MOTHER'S MAIDEN NAME

OLIVA P

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

25-09-7492

17. INFORMANT

MARY T. ANDERSON

ADDRESS

(Same)

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

412.92 I 250.9
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

Anterior - inferior C.V.D.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

10 yr

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

422.1 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

Diabetes mellitus

10 yr

19A. DATE OF OPERATION

0 none

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

—

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

—

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

—

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

—

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

—

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

—

22. I certify that (I) (this hospital) attended the deceased from 1956 19 to Jan. 28 1968, that (I) (we) last saw the deceased alive on 1-27 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

James Moore MD

Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED

1-28-68

23C. PHYSICIAN'S NAME (Type)

J. DUBR MOORES MD

23D. ADDRESS

3105 Belair Rd 21213

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

JAN-31-1968

24C. NAME OF CEMETERY OR CREMATORY

CAK LAWN Cem

24D. LOCATION (City, town, or county) (State)

Baltimore County - Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 29 1968

25B. NAME OF REGISTRAR

Robert E. Fairburn

25C. FUNERAL DIRECTOR

Charles E. Evans

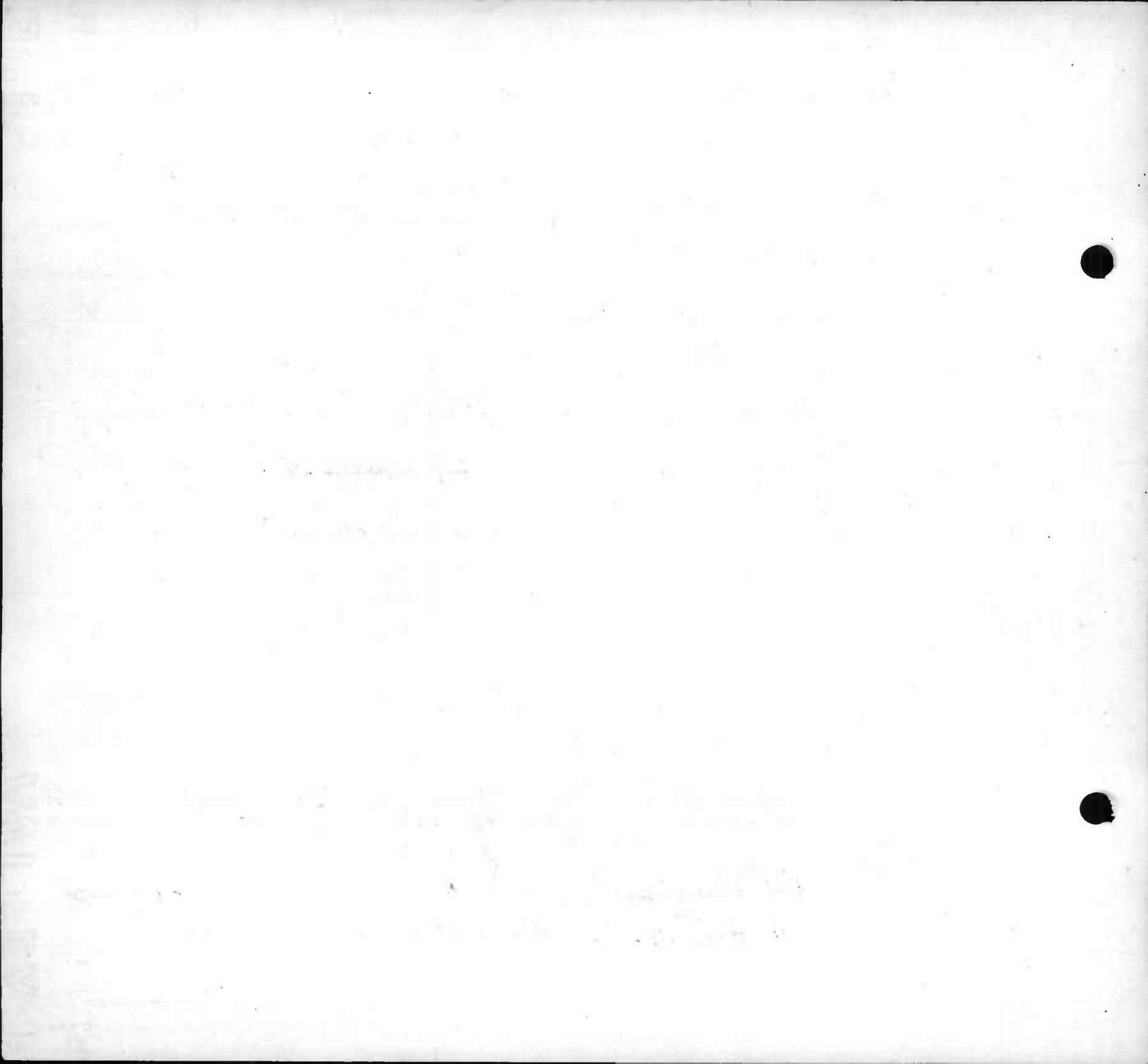
25D. ADDRESS

14005 CHASE ST - 21230

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

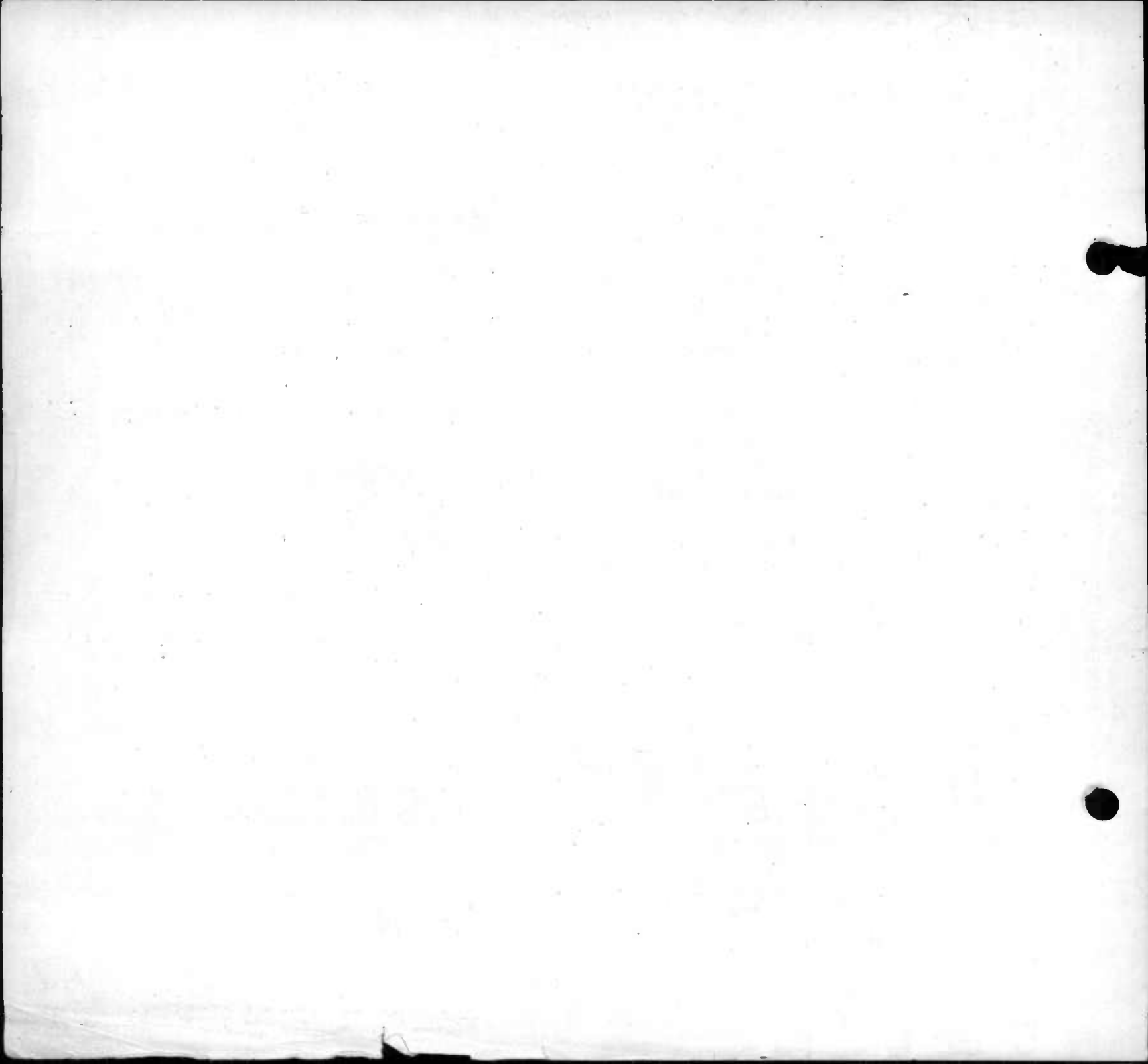
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-1150</u>
68-1150 CERTIFICATE OF DEATH				
BIRTH NO. <u>W-355</u>				
1. NAME OF DECEASED (Type or print) <u>FRANCES E. WITTMAN</u>			2. DATE AND HOUR OF DEATH <u>JANUARY 27 1968</u> <u>8 A</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>2694 ST. BENEDICT ST.</u>			A. STATE <u>MARYLAND</u> B. COUNTY <u>20-05</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>FEMALE</u> 6. RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>OCT. 4, 1904</u> 63	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STERILIZER</u>			11. BIRTHPLACE (State or foreign country) <u>POLAND</u>	
10B. KIND OF BUSINESS OR INDUSTRY <u>HOSPITAL</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>? Scobee</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> <u>NO WE</u>			16. SOCIAL SECURITY NO. <u>174-16-5623</u>	
17. INFORMANT <u>John WITTMAN</u>			ADDRESS <u>2694 ST. BENEDICT ST.</u>	
18. <u>412.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Hypertension CV Disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>arteriosclerosis</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>443X II</u> <u>bronchitis</u>				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 1957</u> to <u>Jan 1968</u> , that (I) (we) last saw the deceased alive on <u>Jan 28 1968</u> and that in (my) (<u>my</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>H. H. Baylus</u>			23B. DATE SIGNED <u>27 Jan 68</u>	
23C. PHYSICIAN'S NAME (Type) <u>H. H. BAYLUS, MD</u>			23D. ADDRESS <u>1600 Wilkins Ave</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-30-68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>
24D. LOCATION (City, town, or county) <u>BALTIMORE, MD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 29 1968</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor, MA</u>		25C. FUNERAL DIRECTOR <u>Geo. E. Shubert</u>		
25D. ADDRESS <u>2101 Frederick Ave</u>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1151
G-650				68-1151
68-1151 CERTIFICATE OF DEATH				
BIRTH NO.		2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) EDGAR P. GRAHAM		1/27/68 2:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSPITAL		A. STATE MD.		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		B. COUNTY		
C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 2233 RAMSAY STREET				
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-31-02	9. AGE (In years last birthday) 65
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DIE SET		10B. KIND OF BUSINESS OR INDUSTRY VULCAN HART		11. BIRTHPLACE (State or foreign country) VIRGINIA
13. FATHER'S NAME ANDREW CLARK GRAHAM		12. CITIZEN OF WHAT COUNTRY? UNITED STATES OF AMERICA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215 05 3899		17. INFORMANT MARIE GRAHAM
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARCINOMA of PANCREAS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF		
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:		
19A. DATE OF OPERATION 1-27-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA of Pancreas		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 11-25 1967 to 1-27 1968 , that (I) (we) last saw the deceased alive on 1-27 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE E. J. ZORICK MD		23B. DATE SIGNED 1-27-68		23C. PHYSICIAN'S NAME (Type) E. J. ZORICK MD
23D. ADDRESS 176H				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-30-68		24C. NAME OF CEMETERY or CREMATORY LAKE VIEW
24D. LOCATION (City, town, or county) (State) CARROLL COUNTY MD.				
25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968		25B. NAME OF REGISTRAR Robert E. Parker		25C. FUNERAL DIRECTOR George Schwab
25D. ADDRESS 2101 Frederick Ave.				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1152

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-1152

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Alfred S. Tryon

2. DATE AND HOUR OF DEATH

Jan. 25, 1968

7³⁰ P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

90 Century Home
102 N. Paca St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN

Baltimore

E. STREET AND NUMBER

3213 Woodland Ave.

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

5. SEX

Male

6. RACE

Cau.

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Jan. 3, 1900

9. AGE (In years last birthday)

68

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Jockey

10B. KIND OF BUSINESS OR INDUSTRY

Horse Race Track

11. BIRTHPLACE (State or foreign country)

Brooklyn, New York

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Frank Tryon

14. MOTHER'S MAIDEN NAME

Martha Stewart

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No

16. SOCIAL SECURITY NO.
217-07-5629

17. INFORMANT

Mrs. Lillie Tryon, 10806 Reisterstown Road

ADDRESS

18.

412.9 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

ONE TO, OR AS A CONSEQUENCE OF:

Cardio Respiratory Failure

Chronic Heart Failure

Pneumonia

(B) DUE TO, OR AS A CONSEQUENCE OF:

Anterograde CVA

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov 4 1966 to Jan 25 1968, that (I) (we) last saw the deceased alive on Jan 25 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S NAME (Type)

Willard Applefeld, M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1/26/68

23D. ADDRESS

6615 Reisterstown Road

24A. BURIAL CREMATION, REMOVAL (Specify)

Cremation

24B. DATE

1/27/68

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cemetery

24D. LOCATION

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 29 1968

25B. NAME OF REGISTRAR

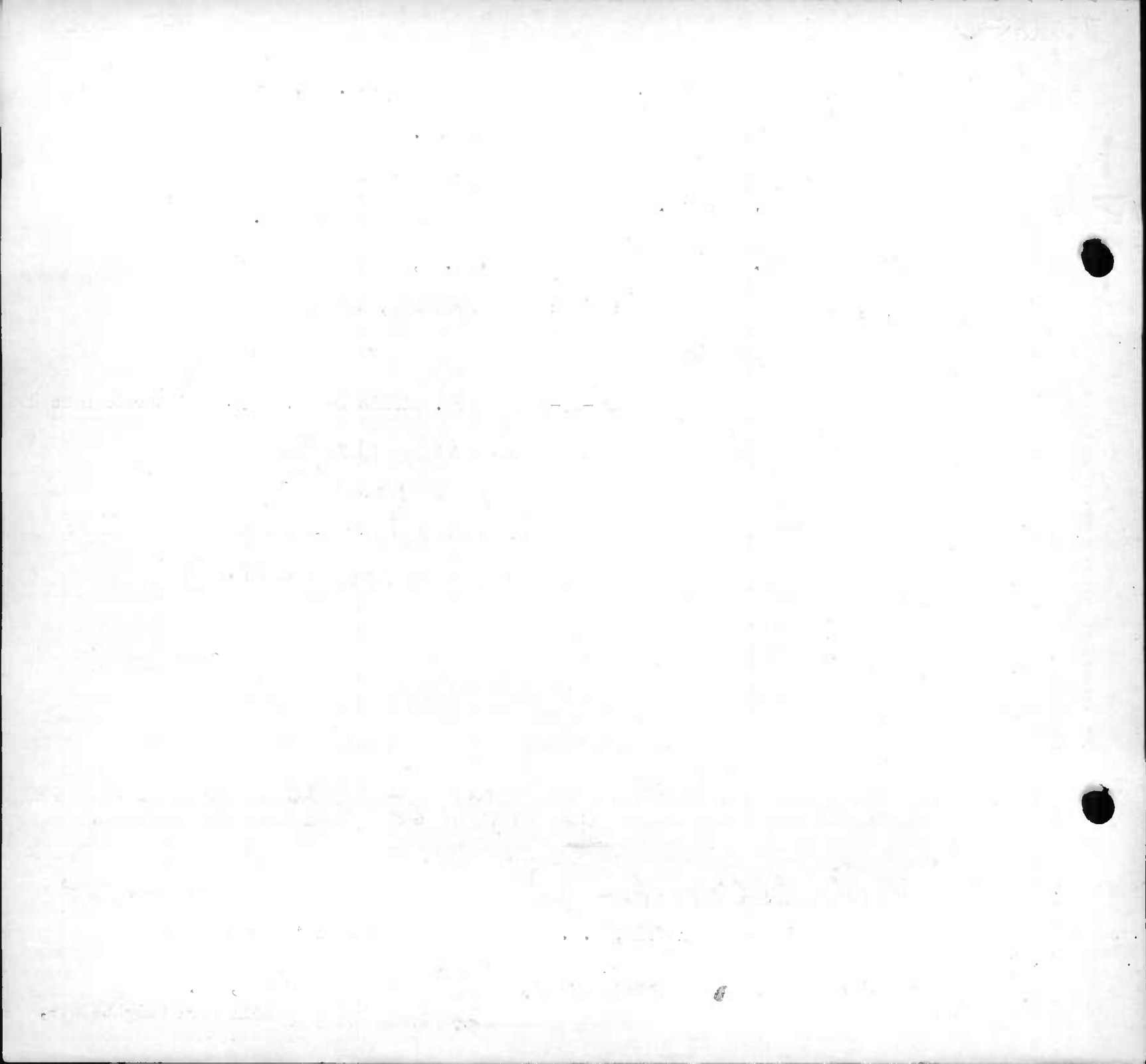
Robert E. Taylor

25C. FUNERAL DIRECTOR

B. Vernon Simon

ADDRESS

4611 Park Heights Ave.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1153

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68-1153

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

HERMAN DIERKER

2. DATE AND HOUR OF DEATH

1/26/68

6 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

38

UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD.

ANNE ARUNDEL, 52-00

C. CITY OR TOWN

Glen Burnie

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

415 A ST. Glen Burnie Md

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

5/18/15

9. AGE (In years last birthday)

52

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

HERMAN H. DIERKER

14. MOTHER'S MAIDEN NAME

MINNIE GRULKEY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

214-18-4259

17. INFORMANT

Mrs. IRENE DIERKER - AS ABOVE

ADDRESS

18. 303.2 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Shock

(B)

DUE TO, OR AS A CONSEQUENCE OF:

GI hemorrhage

(C)

Chronic Alcoholism

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

hours

days

years

322.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

no

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12 PM 1/25 19 68 to 6 AM 1/26 19 68, that (I) (we) lost saw the deceased alive on 1/26 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Michael Kaliner MD

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1/26/68

23C. PHYSICIAN'S NAME (Type)

Michael Kaliner MD

DEGREE

23D. ADDRESS

UNIV Hosp Dept Med

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

1/28/68

24C. NAME OF CEMETERY or CREMATORY

Wesley Chapel Cemetery

24D. LOCATION

(City, town, or county)

Rock Hall, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 29 1968

25B. NAME OF REGISTRAR

Robert E. Fink, MD

25C. FUNERAL DIRECTOR

Raymond C. Fink, Glen Burnie, Md.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-1154</u>
BIRTH NO. <u>68-01407</u>		68-1154		CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) WERTZ, BABY BOY		2. DATE AND HOUR OF DEATH JANUARY 20, 1968 4:20 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MARYLAND 21229		A. STATE MD. B. COUNTY 21222		
		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 1904 SNYDER AVE.		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 01/20/68	9. AGE (In years last birthday) 16
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME GARY		14. MOTHER'S MAIDEN NAME HELFRICH, NANCY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ST AGNES HOSPITAL WILKENS & CATON AVE
18. 777 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Maternity</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
19. 776 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JANUARY 20, 1968 to JANUARY 20, 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JANUARY 20, 1968 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.				
23A. SIGNATURE <i>David B McIntyre</i>				23B. DATE SIGNED 1-22-68
23C. PHYSICIAN'S NAME (Type) DAVID B MCINTYRE		23D. ADDRESS WILKENS & CATON AVES. BALTO., MD 21229		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-29-68		24C. NAME OF CEMETERY or CREMATORY BALTIMORE NATIONAL CEM
24D. LOCATION 5501 FREDERICK AVE. BALTO., MD.				
25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968		25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR <i>Charles S. Guler</i>
				ADDRESS 901 S. CONKLING ST. BALTO., 21224, MD.

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Released as Non Med. for the Medical Examiners Office by Springfield

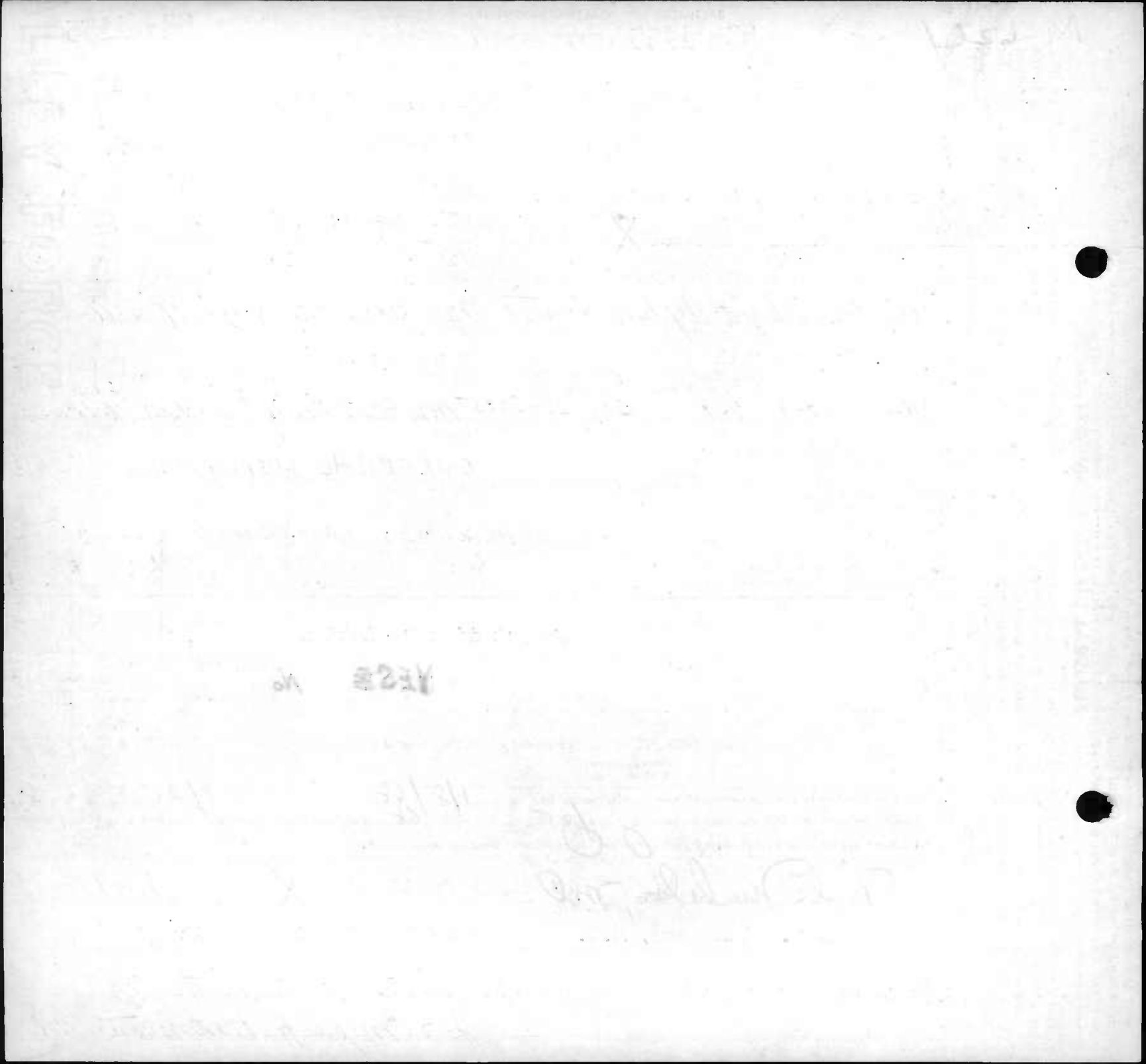
68- 1155

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

REG. NO.

68- 1155

1. NAME OF DECEASED (Type or Print) JOHN MARSHALL M.D.		2. DATE AND HOUR OF DEATH 1/25/68 12:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD The Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore	
5. FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital		C. CITY OR TOWN Baltimore Co D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6. SEX Male 7. RACE White 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 43 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Anesthesiologist Hopkins Hospital		11. BIRTHPLACE (State or foreign country) New York City N.Y. - U.S.A.	
13. FATHER'S NAME Tola Marshall		14. MOTHER'S MAIDEN NAME Lael Brown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes 1951-1954		16. SOCIAL SECURITY NO. 509-22-5225	
18. 430.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.)		17. INFORMANT Mrs Edith Lindy Marshall ADDRESS Same as above	
19A. DATE OF OPERATION 330X II		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from 1/18/68 to 1/25/68 and that (I) (we) lost saw the deceased alive on 1/25/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
23A. SIGNATURE Paul E. Michelson, M.D.		23B. DATE SIGNED 1/25/68	
23C. PHYSICIAN'S NAME (Type) Paul E. Michelson, M.D.		23D. ADDRESS The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/29/68	
24C. NAME OF CEMETERY or CREMATORY Westminster Cemetery		24D. LOCATION (City, town, or county) (State) Westminster, Md.	
25A. DATE REC'D BY HEALTH DEPT. 1/29/68		25B. NAME OF REGISTRAR Paul E. Michelson	
25C. FUNERAL DIRECTOR J. S. Smyers Jr., Westminster, Md.		25D. ADDRESS	

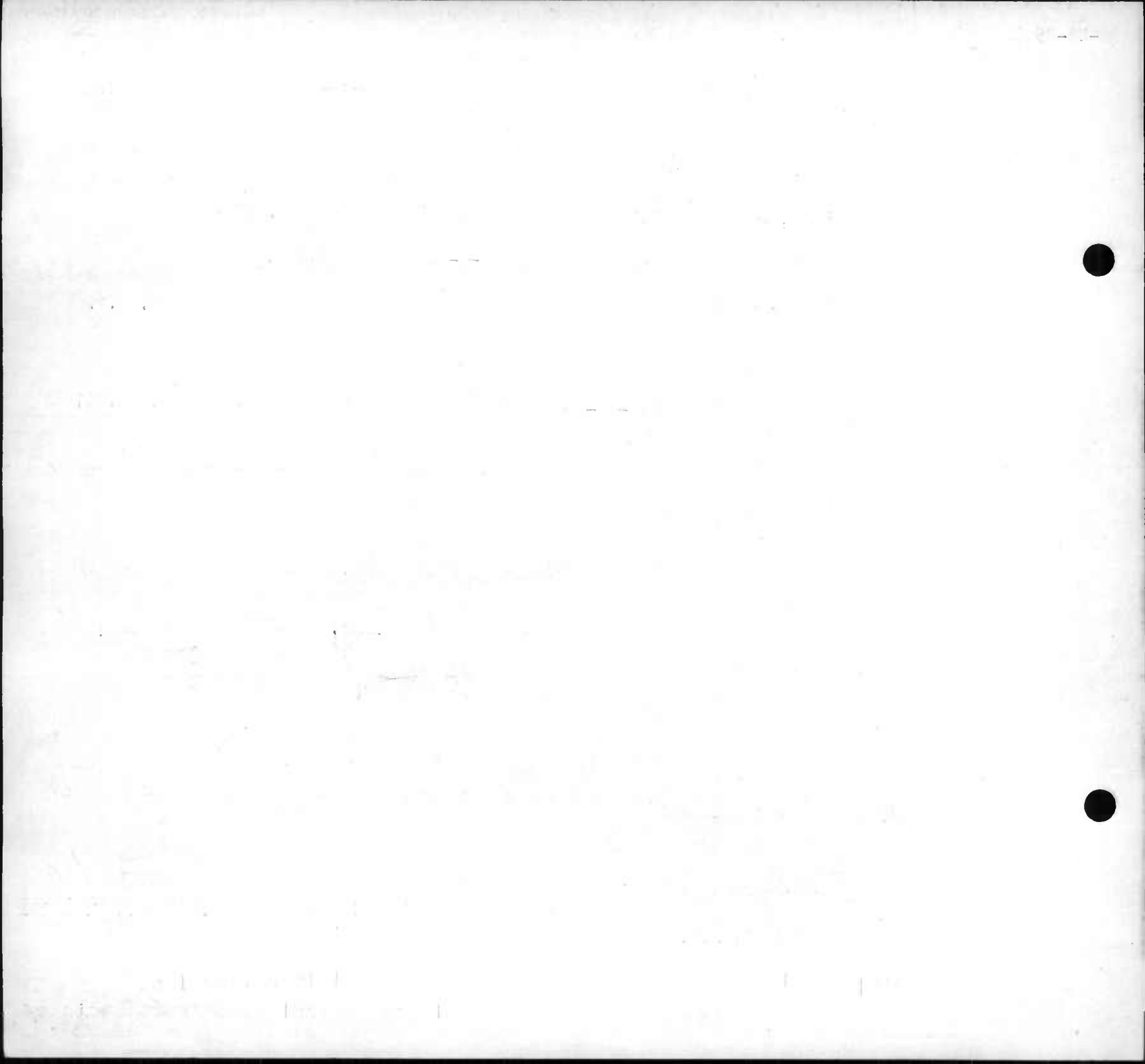


50-28-85 LB

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

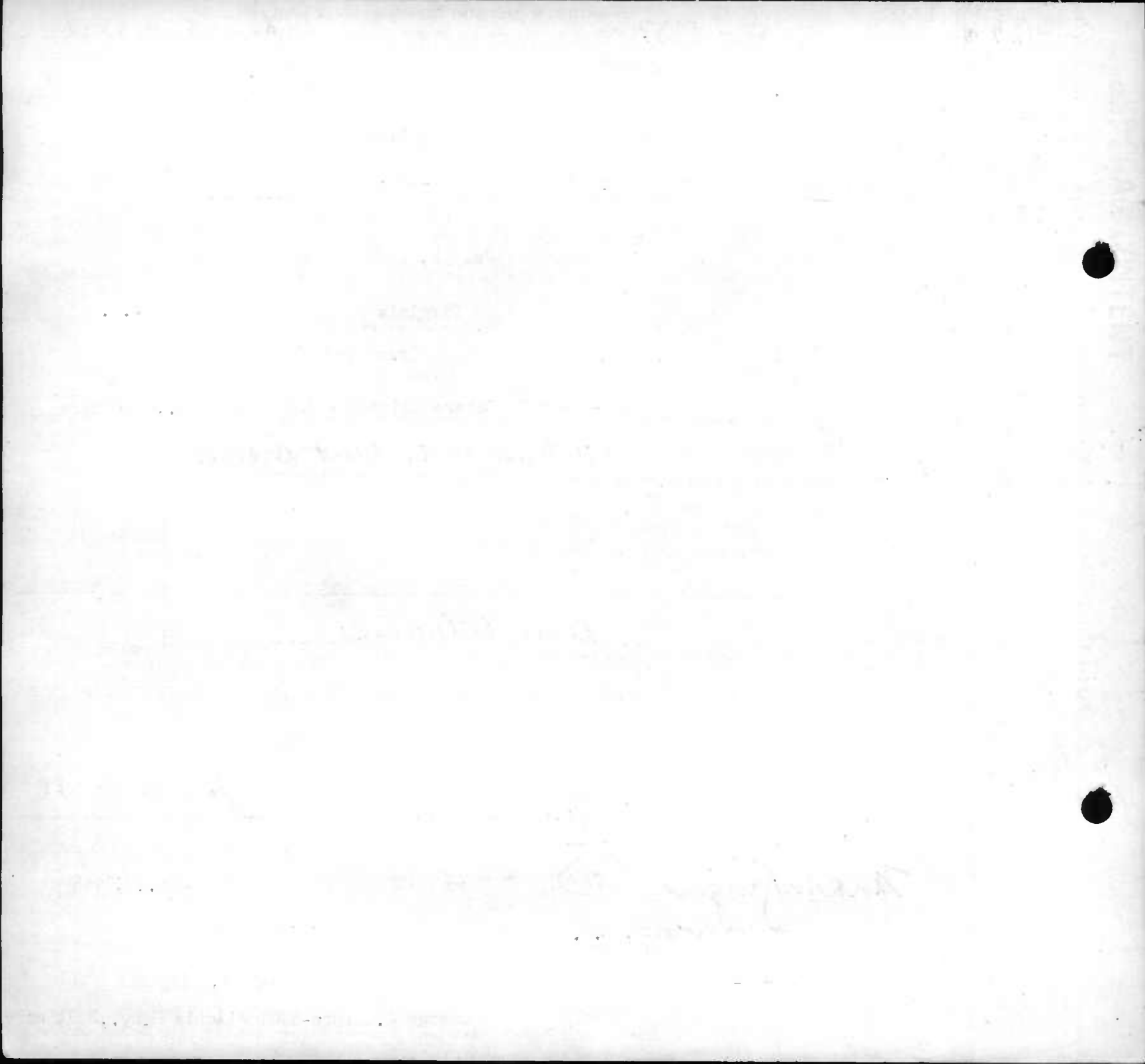
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1156	
BIRTH NO. E-645		68-1156	
1. NAME OF DECEASED (Type or Print) F. GEORGE ERLINE		2. DATE AND HOUR OF DEATH 1-25-68 9:45 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224		MARYLAND	
C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER		578 BEECHFIELD AVE. #21229	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-9-81
9. AGE (In years last birthday) 86 87		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FURNITURE FINISHER	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN ERLINE		14. MOTHER'S MAIDEN NAME MARY ZIMMERMAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-05-6551A	
17. INFORMANT ADDRESS BALTIMORE CITY HOSPITALS RECORDS: 4940 EASTERN AVE., BALTO., MD. #21224		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: AS Cardiac Disease 3 yrs	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: 1 mo.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Monocytic Leukemia 2 wks	
420.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		prob Pul Infarct	
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from October 2, 1967 to JAN 25, 1968, the (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE Fredy. Aoki MD		23B. DATE SIGNED Jan 25/68	
23C. PHYSICIAN'S NAME (Type) FRED AOKI, M.D.		23D. ADDRESS 4940 EASTERN AVENUE, BALTO., MD. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 1/30/68	24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968	25B. NAME OF REGISTRAR Robert E. Farber	25C. FUNERAL DIRECTOR ADDRESS Walters Funeral Home Pratt & Stricker Sts.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				68- 1157		REG. NO. 68- 1157	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) DORA M. GRUBB			
2. DATE AND HOUR OF DEATH January 26, 1968				M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 9.9.C 52-00 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 934 First Street			
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1888	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME Joshua Grubb				
14. MOTHER'S MAIDEN NAME Grace Vestal			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				
16. SOCIAL SECURITY NO. R1 228-54-9682			17. INFORMANT ADDRESS Lenore Clinton - 107 Church St., Baltimore				
18. 412.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Renal lithiasis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1965 19 to Jan. 26 19 68 , that (I) (we) last saw the deceased alive on Jan. 26 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Morton Kreiger, M.D.				23B. DATE SIGNED Jan. 27, 1968		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) Morton Kreiger, M.D.				23D. ADDRESS 615 Hammonds Lane			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-30-1968		24C. NAME OF CEMETERY or CREMATORY Green Wood Cemetery		24D. LOCATION (City, town, or county) (State) Damascus, Virginia	
25A. DATE REC'D BY HEALTH DEPT. JAN 28 1968		25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR ADDRESS George J. Gonce-4001 Ritchie Hgwy., Baltimore			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1158

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-1158

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

RUSSELL A. CONDIFF

2. DATE AND HOUR OF DEATH

January 25, 1968

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

43 South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md.

A.A.Co.

52-00

C. CITY OR TOWN

Brooklyn Park

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

100 E. 11th Ave. #25

5. SEX

Male

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

May 30, 1913

9. AGE (In years
lost birthday)

54

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Truck Driver

10B. KIND OF BUSINESS OR INDUSTRY

Transportation

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Allen G. Condiff

14. MOTHER'S MAIDEN NAME

Sarah E. Foster

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

215-09-9317

17. INFORMANT

Maude Condiff - (same)

ADDRESS

18. 5-71-01

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

Heart Attack

2 wks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

Paenetic's Condition

5 yrs.

(C) DUE TO, OR AS A CONSEQUENCE OF:

Empty Stomach + Bacteremia

10 yrs

581.1

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-6-68 to 1-25-68
that (I) (we) last saw the deceased alive on 1-25-68 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

E. Hunter Wilson, Jr., M.D.

DEGREE

Attending
Phys. ☒

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

1-26-1968

23C. PHYSICIAN'S
NAME (Type)

23D. ADDRESS

805 Med. Arts Bldg., Baltimore, Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1-29-1968

24C. NAME OF CEMETERY or CREMATORY

Cedar Hill Cemetery

24D. LOCATION

(City, town, or county)

(State)

Ritchie Hwy., A.A.Co., Maryland

25A. DATE REC'D BY HEALTH DEPT.

JAN 29 1968

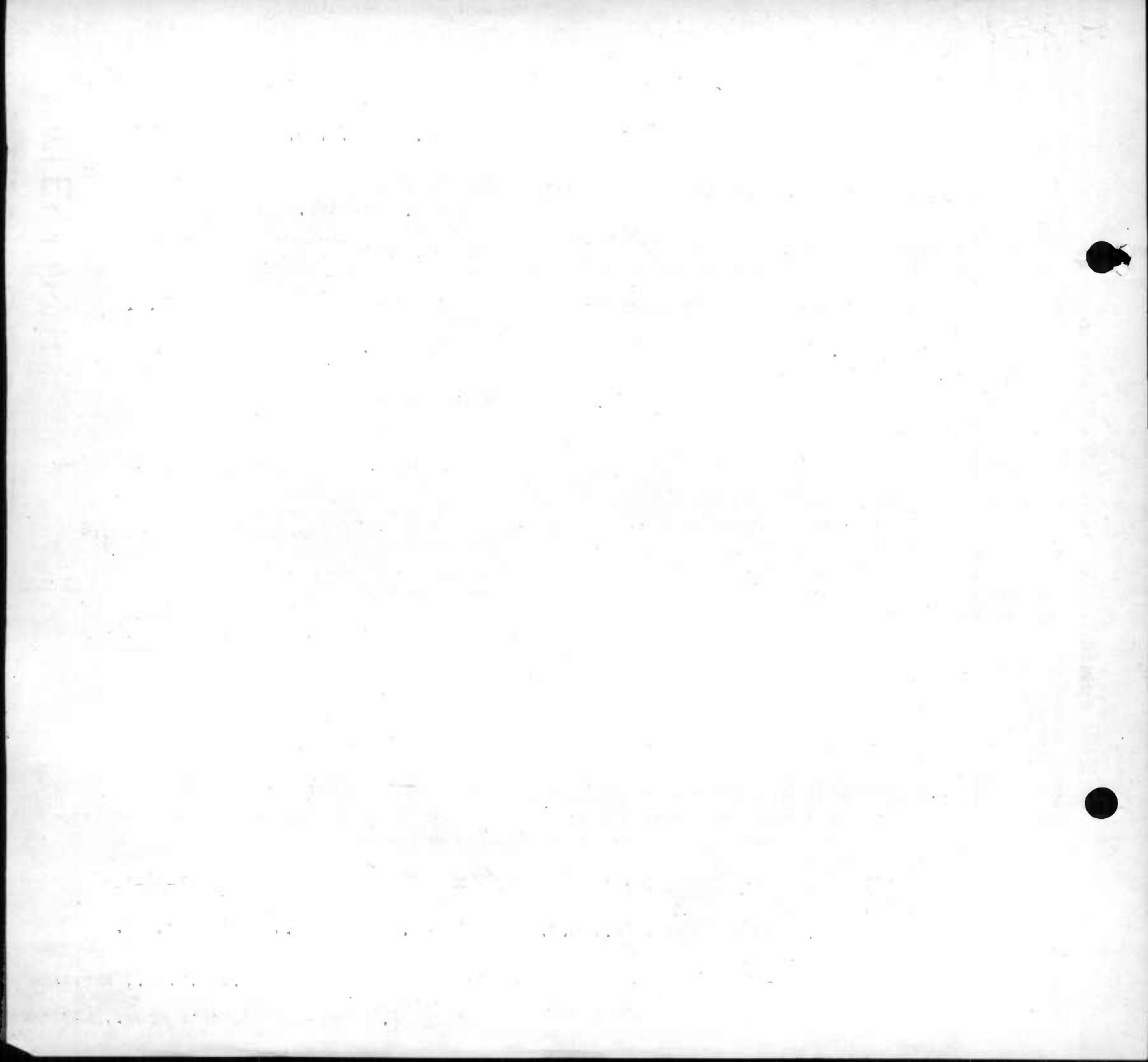
25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

ADDRESS

George J. Gonce-4001 Ritchie Hwy., Baltimore



FUNERAL DIRECTOR: IMPORTANT

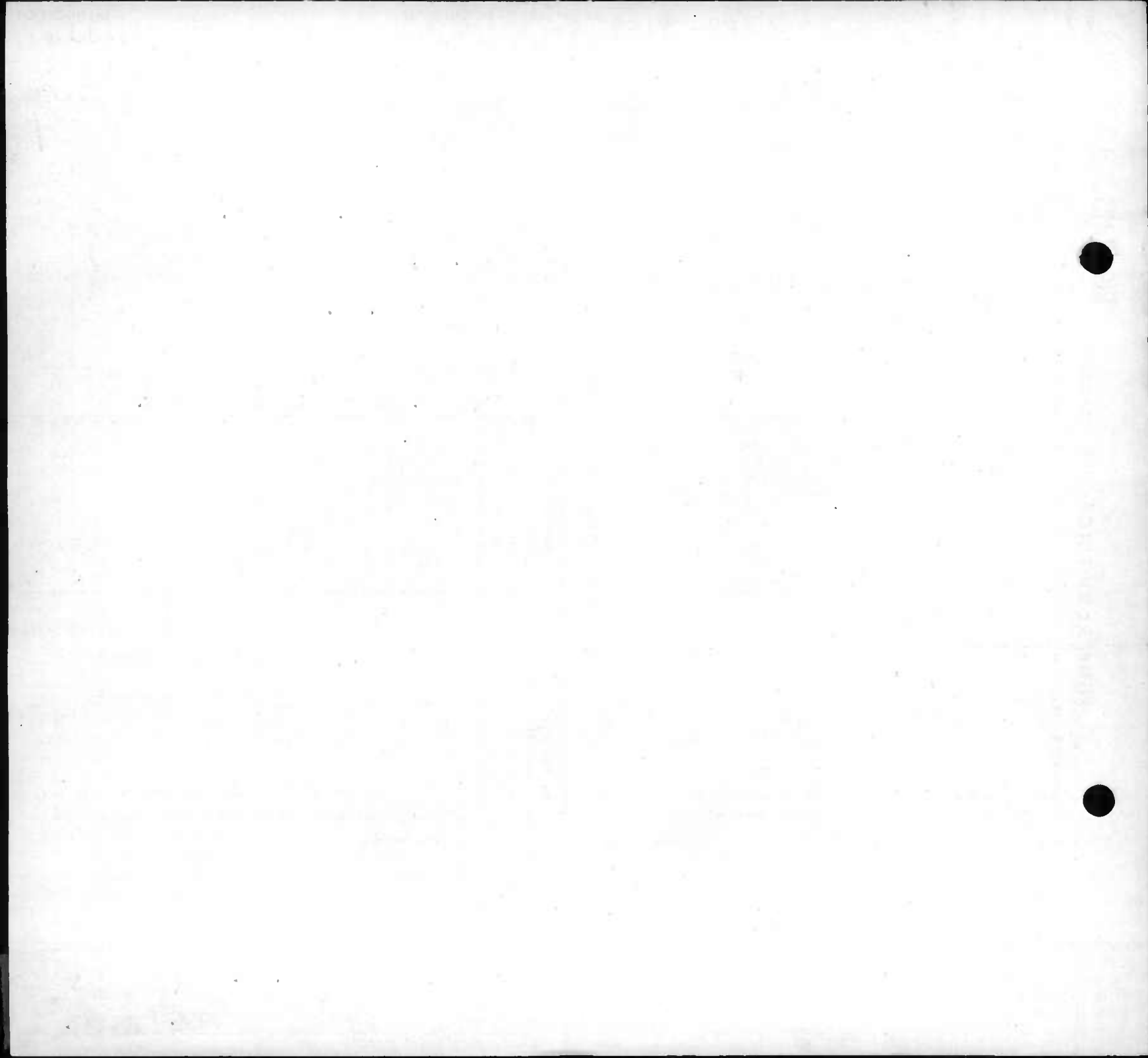
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1159

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-1159

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Catherine A. Huber</i>		2. DATE AND HOUR OF DEATH <i>1-28-68</i> <i>6:55</i> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>37 MERCY HOSP, INC</i>				C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>19 W. Ostend St.</i>					
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug. 24, 1904</i>	9. AGE (In years last birthday) <i>63</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bookkeeper</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Clothing</i>		11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>	
13. FATHER'S NAME <i>Charles Snyder</i>				12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Henry J. Huber</i>				ADDRESS <i>823 Wedgewood Rd.</i>	
18. <i>183.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cacheexia</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Malnutrition</i> (C) <i>Ovarian CA with metastasis. 2 yrs</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 Mo</i> <i>3 Mo</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>175.0 II</i>					
19A. DATE OF OPERATION <i>1-10-68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>ascites</i>		20A. AUTOPSY? (Yes or No) <i>No</i> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from <i>1-8-68</i> 19 <i>68</i> to <i>1-28</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>1-28</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Narong Ruang Ruchira</i>				23B. DATE SIGNED <i>1-28-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>NARONG RUANG RUCHIRA</i>				23D. ADDRESS <i>M. H.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1 31 68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer</i>	
24D. LOCATION <i>Balto. Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 29 1968</i>		25B. NAME OF REGISTRAR <i>Dr. E. E. Feltner</i>		25C. FUNERAL DIRECTOR <i>Mc Cully</i>	
				ADDRESS <i>130 E. Fort Ave.</i>	



50-78-07 LB

5-351

68-1160

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-1160

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

HOWARD J. STUMPF

2. DATE AND HOUR OF DEATH

1/26/68

5:45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

31

BALTIMORE CITY HOSPITAL
4940 EASTERN AVENUE
BALTIMORE, MARYLAND 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

BALTIMORE

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

609 Annabelle Ave.

21225

5. SEX

Male

6. RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

5-4-09

9. AGE (In years
last birthday)

58

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

IRON WORKER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

WILLIAM STUMPF
WILLIAM STUMPF

14. MOTHER'S MAIDEN NAME

Christine Nannale
CHRISTINE NANNALE15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218 18 63 22

17. INFORMANT

RECORDS: BALTIMORE CITY HOSPITALS

ADDRESS

4940 EASTERN AVE., BALTO., MD. 21224

18.

1619 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

obstruction of larynx

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Carcinoma of larynx

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

161X

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from 18th December 1967 to 1/26/68 19
that (X) (we) last saw the deceased alive on 1/26/68 19 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above, (X) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Robert H. Bessin

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

1/26/68

23C. PHYSICIAN'S
NAME (Type)

Robert H. Bessin

23D. ADDRESS

Baltimore City Hospital
4940 EASTERN AVE., BALTO., MD. 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1/30/68

24C. NAME OF CEMETERY or CREMATORY

Glen Haven Cem.

24D. LOCATION

Glen Burnie

AA Co

Md

25A. DATE REC'D BY HEALTH DEPT.

JAN 29 1968

25B. NAME OF REGISTRAR

Robert E. Fickens

25C. FUNERAL DIRECTOR

Mc Gully F.H. 237 Patapsco Ave

ADDRESS

21225

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

23/12

For the year
1911

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1161

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 1161

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ANNA C. PIPPIN		2. DATE AND HOUR OF DEATH January 26, 1968 8⁵⁰ P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Date of Birth 9/13/1879			E. STREET AND NUMBER 1510 BOLTON STREET		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1879 09/13/1879	9. AGE (In years lost birthday) 88 85
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME COMEGYS Cosden		14. MOTHER'S MAIDEN NAME ANNA WHEATLEY		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT ROBERT C. PIPPIN	
18. 412.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) BRONCHO PNEUMONIA		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 DAYS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD			
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 422.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>this hospital</u> attended the deceased from December 27 1967 to January 26 1968 , that (I) <u>(we)</u> last saw the deceased alive on January 26 1968 and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE Enrique Cipriani M.D.				23B. DATE SIGNED 1/26/68	
23C. PHYSICIAN'S NAME (Type) ENRIQUE CIPRIANI M.D.				23D. ADDRESS 33rd & Calvert Sts.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/30/68		24C. NAME OF CEMETERY OR CREMATORY Chester Cemetery	
24D. LOCATION (City, town, or county) (State) Chestertown, Md.		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Tolson	
25C. FUNERAL DIRECTOR William Wells		ADDRESS Chestertown, Md.			

JAN 29 1968

MEMORANDUM FOR THE RECORD

DATE: 10/15/54

TO: MR. TOLSON

FROM: MR. CLEGG

SUBJECT: [illegible]

[illegible]

[illegible]

[illegible]

Approved: [illegible]
Special Agent in Charge

X

10/15/54

68- 1162

BALTIMORE CITY HEALTH DEPARTMENT

68- 1162

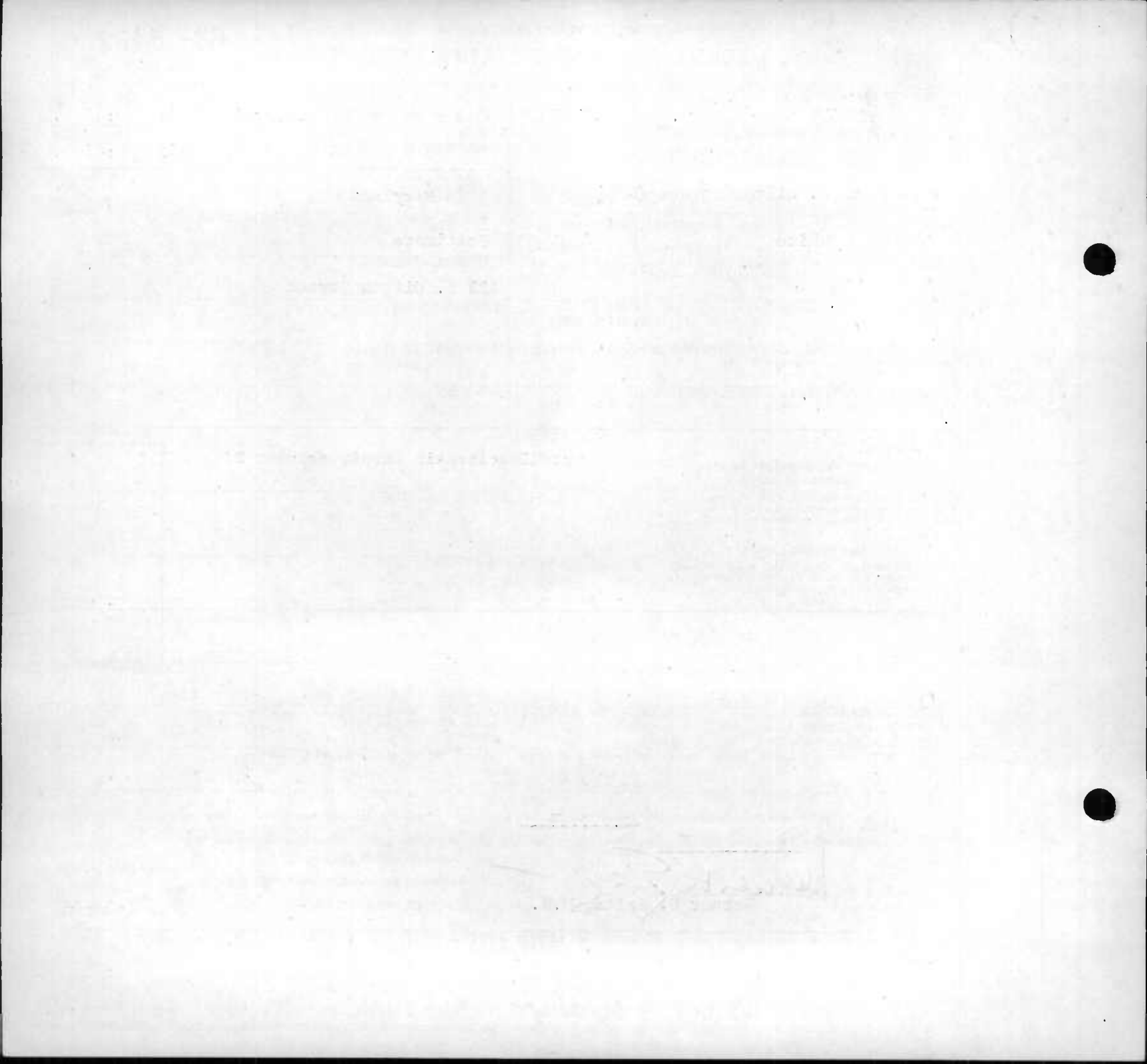
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) AMELIA C. JACKSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> January 18, 1968 9:45 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 122 S. Hilton Street (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour January 18, 1968 9:45 P. M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2047	
9. DATE OF BIRTH		10. AGE (In years lost birthday) 58	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME		18. INFORMANT ADDRESS	

MEDICAL CERTIFICATION	19. 412.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
	20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No
	22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
	22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-19-68					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1/29/68		24C. NAME OF CEMETERY OR CREMATORY ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JAN 30 1968		25B. NAME OF REGISTRAR Robert E. Feltz		25C. FUNERAL DIRECTOR UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1163
CERTIFICATE OF DEATH				
BIRTH NO.		1. NAME OF DECEASED (Type or Print) CHUPKA WILLIAM M.		
2. DATE AND HOUR OF DEATH JANUARY 27, 1968 6:15 A.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD ST AGNES HOSPITAL WILKENS AND CATON AVENUE BALTIMORE MARYLAND 21229		
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 21228		5. SEX MALE 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER 35 HOLMEHURST AVENUE		8. DATE OF BIRTH 01/29/86 9. AGE (In years last birthday) 81		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WEAVER		10B. KIND OF BUSINESS OR INDUSTRY RET.		11. BIRTHPLACE (State or foreign country) CZECHOSLOVAKIA
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 029-01-9493		17. INFORMANT ADDRESS ST AGNES HOSPITAL WILKENS & CATON AVE
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) Arteriosclerosis Cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diabetes mellitus				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 260X II				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (X) (this hospital) attended the deceased from JANUARY 15 19 68 to JANUARY 27 19 68 , that (XX) (we) lost saw the deceased alive on JANUARY 27 19 68 and that in (my) (our) apinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.				
23A. SIGNATURE Carolyn Pass, M.D.		23B. DATE SIGNED 1-27-68		23C. PHYSICIAN'S NAME (Type) CAROLYN PASS, M. D.
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 2/1/68		24C. NAME OF CEMETERY or CREMATORY ST. DENNIS
24D. LOCATION (City, town, or county) (State) E. DOUGLAS, MASS.		25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968		
25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR ADDRESS E 8 Mae Nabb Catonsville Md.		

• 24 •

18

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.
D-200		68-1164		68-1164
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
JOHN DIGGS		Jan 25, 1968 12:50 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY		
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		Maryland		
31		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 642 North Fulton Avenue 21217		
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8-26-1900	9. AGE (In years last birthday) 67
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement Finisher		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia, Lancaster Co., U.S.A.
13. FATHER'S NAME Moses Diggs		14. MOTHER'S MAIDEN NAME Martha Logan		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-11-8100A		17. INFORMANT Records: BCH-4940 Eastern Avenue 21224
18. 185X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ? Pulm. Embolism (B) Metastatic Prostatic Carcinoma 7 yrs. (C) _____		
177X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 21		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22. I certify that (I) (this hospital) attended the deceased from 1-16-19 68 to 1-25-19 68, that (I) (we) last saw the deceased alive on 1-25-19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Donald I. Saltzman		23B. DATE SIGNED 1/25/68		23C. PHYSICIAN'S NAME (Type) Donald I. Saltzman
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-29-68		24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968		
25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Morton E. Dyett F.H.		
25D. ADDRESS 1701 Lourens				

87

1991-25-

474

1991-25-474
1991-25-474

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 1165

BIRTH NO.

REG. NO.

1. NAME OF DECEASED **E.**
(Type or Print)**GREGORY SCOTT**2. DATE OF DEATH Known ☒ Estimated ☐ Month Day Year Hour
1 26 68 3:15 p m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

37 Provident Hospital3. DATE PRONOUNCED DEAD Month Day Year Hour
January 26, 1968 3:15 p m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE **Maryland**

B. COUNTY

6. SEX

Male

7. RACE

Colored8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS

YES ☒ NO ☐

9. DATE OF BIRTH

6-19-1948

10. AGE (In years last birthday)

19

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

3612 Eldorado Ave.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ALVIN E. SCOTT

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

ELIZABETH BROOKS

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

216-52-3602

18. INFORMANT

Mrs. Elizabeth Day

ADDRESS

3612 Eldorado19. **E 965 X**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

Multiple gunshot wounds of the back

(A) IMMEDIATE CAUSE and chest app. 38 caliber
DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

St.

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

Smithson and Pennsylvania Ave.

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

1 26 68 3:10 p.

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject shot several times in the back

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S

NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 27, 1968

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

2-1-68

24C. NAME OF CEMETERY or CREMATORY

Mount Auburn Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JAN 29 1968

25B. NAME OF REGISTRAR

Robert E. Fickens

25C. FUNERAL DIRECTOR

MORTON & DYETT F.H. 1701 Laurens St.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

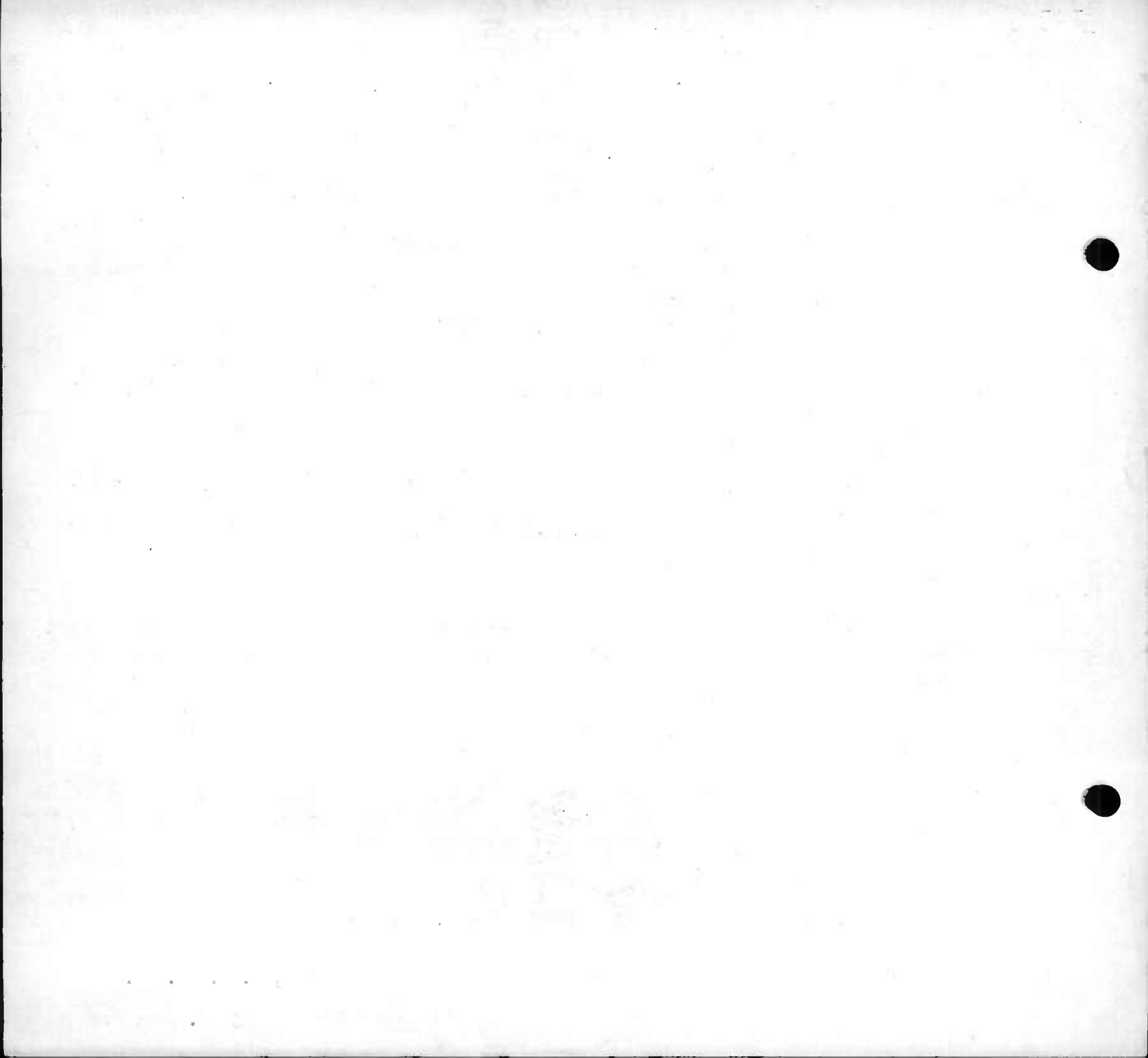
BALTIMORE CITY HEALTH DEPARTMENT				68- 1166		REG. NO. 68- 1166	
BIRTH NO. 68- 1166				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JUDSON WRIGHT				2. DATE AND HOUR OF DEATH 1-27-68, 6:45 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSPITAL OF MD 730- ASH BURTON STREET,				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 25-33 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 23- 2412, HURON STREET			
5. SEX M	6. RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-18-84	9. AGE (In years last birthday) 83	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10B. KIND OF BUSINESS OR INDUSTRY Kenn. Railroad		11. BIRTHPLACE (State or foreign country) Norfolk, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Wright				14. MOTHER'S MAIDEN NAME Texanna Wright			
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Viola Boone		ADDRESS 2412 Huron Ave	
18. 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. 260X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE URAEMIA DUE TO, OR AS A CONSEQUENCE OF: (B) ASCVD, SEVERE ANAEMIA, MALNUTRITION DUE TO, OR AS A CONSEQUENCE OF: (C) DIABETES MELLITUS, GANGRENE FOOT APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12-12-1967 to 1-27-1968 , that (I) (we) last saw the deceased alive on 1-27-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Thankam B. Pillai				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) THANKAM B. PILLAI				23D. ADDRESS 730- ASHBURTON STREET			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-31-68		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 29 1968		25B. NAME OF REGISTRAR R. B. E. Taylor		25C. FUNERAL DIRECTOR Morton E. Dyett F.H.		ADDRESS 1701 Laurens St	

Handwritten text, possibly a signature or name, appearing in the upper right quadrant of the page.

Handwritten text at the bottom of the page, possibly a date or reference number.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1167	
K-610 68-1167				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) KRAPP, JOSEPH B.				2. DATE AND HOUR OF DEATH 1/27/68 8:16 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE MARYLAND 21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1210 BATTERY AVENUE 21230	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-3-1882	9. AGE (In years last birth) 85	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lithographer		10B. KIND OF BUSINESS OR INDUSTRY U.S. PRINTING		11. BIRTHPLACE (State or foreign country) OHIO	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME GEORGE		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-03-9571		17. INFORMANT RECORDS, BALTIMORE CITY HOSPITALS ADDRESS 4940 EASTERN AVENUE BALTIMORE MD. 21224	
18. 412.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CAUSE OF DEATH (A) IMMEDIATE CAUSE pneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) ASCVD DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 20 yrs.					
19. 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). chronic brain disease 20 yrs.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/22 19 68 to 1/27 19 68, that (X) (we) last saw the deceased alive on 1/27/68 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E.M. Levinsohn, M.D. DEGREE				23B. DATE SIGNED 1/27/68	
23C. PHYSICIAN'S NAME (Type) E. M. LEVINSOHN DEGREE				23D. ADDRESS 4940 EASTERN AVENUE BALTIMORE CITY HOSPITALS 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1 31 68		24C. NAME OF CEMETERY or CREMATORY Holy Cross	
24D. LOCATION Brooklyn, A. A. Co. Md.		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
24G. FUNERAL DIRECTOR Mc Cully		24H. ADDRESS 130 E. Fort Ave		24I. DATE 1/29 1968	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1168 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 68-1168	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Stein SR HARRY M.</i>		2. DATE AND HOUR OF DEATH <i>Jan. 28, 1968</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>43 South Balto. Gen. Hosp.</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>3215 Hamilton Ave.</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 1, 1905</i>	9. AGE (In years last birthday) <i>62</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Clothing</i>		11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>	
13. FATHER'S NAME <i>Unknown Stein</i>		14. MOTHER'S MAIDEN NAME <i>Rose Unknown</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Harry M. Stein Jr. 3215 Hamilton Ave.</i>	
18. <i>486X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>Basilar artery thrombosis</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>pneumonia</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
19A. DATE OF OPERATION <i>1-25-68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>brachy-bronchial toilet</i>		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>78</i>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1-25-1968</i> to <i>1-28-1968</i> , that (I) (we) last saw the deceased alive on <i>1-28-1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Richard H. Reed M.D.</i>				23B. DATE SIGNED <i>1-28-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>R</i>				23D. ADDRESS <i>Mc Gully 130 E. Fort Ave</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>21 68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Cedar Hill</i>	
24D. LOCATION (City, town, or county) (State) <i>Brooklyn, A. A. Co. Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 29 1968</i>			
25B. NAME OF REGISTRAR <i>Robert E. Farkner</i>		25C. FUNERAL DIRECTOR <i>Mc Gully</i>			

1870

1870

1870

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1169

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

REG. NO.

68- 1169

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MAFFEI, MARIA. C

2. DATE AND HOUR OF DEATH

27th JAN. 1968 8:10 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

6 FRANKLIN SQUARE HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

M.D

18-02

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

LINCOLN NURSING HOME

5. SEX

F

6. RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

3/16/03

9. AGE (In years last birthday)

64

If Under 1 Yr. Months: Days

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

UNEMPLOYED

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

ITALY

12. CITIZEN OF WHAT COUNTRY?

U. S. A

13. FATHER'S NAME

AUGUSTINE, MAFFEI.

14. MOTHER'S MAIDEN NAME

DI. GIRALMO.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

128-14-0438

17. INFORMANT

JOSEPHINE NYKYFORCHYN

ADDRESS

6711 Penfield Rd.

18. 285.91

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE SHOCK due to DUE TO, OR AS A CONSEQUENCE OF:

(B) Hypovolemia(?) DUE TO, OR AS A CONSEQUENCE OF:

(C).....

293 X

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 25th JAN 19 68 to 27th JAN 19 68, that (I) (we) last saw the deceased alive on 6:10 PM 27th JAN 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

C. D. Kwon

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

27th JAN. '68

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

2-1-68

24C. NAME of CEMETERY or CREMATORY

Glen Haven Cem.

24D. LOCATION

(City, town, or county)

Glen Burnie, Md

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 30 1968

25B. NAME OF REGISTRAR

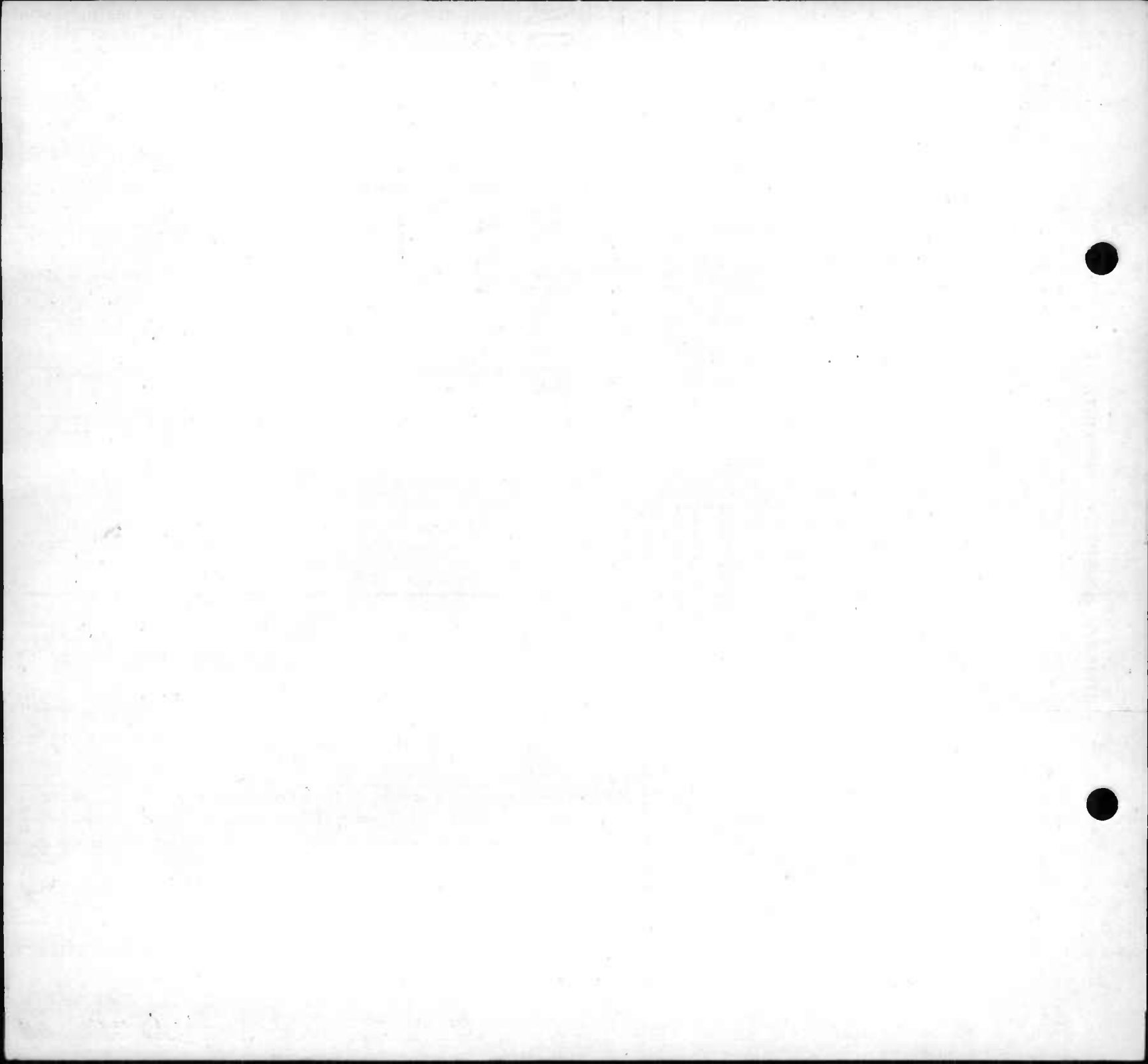
Robert E. Falduto

25C. FUNERAL DIRECTOR

John H. HANNA Funeral Home, 4200 Pennington Ave

ADDRESS

Belt 26



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1170	
BIRTH NO. 68-01784 68-1170				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Howard, Baby Girl</u>			2. DATE AND HOUR OF DEATH <u>Jan 23, 1968</u> <u>8:32</u> P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Johns Hopkins Hospital</u> <u>33</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>6-03</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>419 N. PATTERSON PARK AVENUE</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 23, 1968</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME <u>BRENDA</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>758.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CONGENITAL ANOMALIES</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ATELECTASIS</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Congenital Anomalies</u> (B) <u>Atelectasis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. <u>759.3 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 23</u> 19 <u>68</u> to <u>Jan 23</u> 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>Jan 23</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J. Wm. Flynt, Jr.</u> M.D. DEGREE				23B. DATE SIGNED <u>1/23/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>J. WM. FLYNT, JR. M.D.</u> DEGREE				23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>1/23/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>The Johns Hopkins Hospital</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto., Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 30 1968</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>HOSPITAL DISPOSAL</u>			

U. S. N. T.

FILE

U. S. N. T.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-1501

68-1171

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

68-1171

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HYMAN REBIN

2. DATE AND HOUR OF DEATH

1/27/68 2:20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

425 Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY
Ant Sinai Nursing Home

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore Md. 27-16

D. STREET ADDRESS (If rural, give locality)

4613 Park Heights Ave.

5. SEX

Male

6. RACE

W

7. MARRIED, NEVER MARRIED

Widowed

8. DATE OF BIRTH

7-1-1893

9. AGE (In years)

75

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Tailor

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

215-52-0721

17. INFORMANT

Goldie Levine 116 University PK 32

ADDRESS

apt

18. 536.9 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) G.I. Bleeding

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

13 days

578X II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/26/68 19 to 1/27/68 19, that (I) (we) last saw the deceased alive on 1/27/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

B. E. TINGER

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1/27/68

23C. PHYSICIAN'S NAME (Type)

B. E. TINGER

23D. ADDRESS

M.D.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1-28-68

24C. NAME OF CEMETERY or CREMATORY

Mt. Airy Korean Cem.

24D. LOCATION

Herring Run Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.

JAN 30 1968

25B. NAME OF REGISTRAR

Robert E. Tinker

25C. FUNERAL DIRECTOR

Jack Lewis Inc. 2100 East Ave. Md.

ADDRESS

Good terms one 2120
Barnes 1-22-62 2120-62 2120-62 2120-62

212-22-021 212-22-021 212-22-021

The Bureau
Trailer
Map No. 212-22-021

James Hospital

James
212-22-021
212-22-021
212-22-021

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1172 CERTIFICATE OF DEATH

REG. NO.

68-1172

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WILMER ERWIN WIEAND

2. DATE AND HOUR OF DEATH

28 JAN. 1968 12:10 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

GOULD CONValesCENT HOME
90 6116 BELAIR Rd.
BALTO. MD 21206

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MD

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

6103 HAMILTON AVE.

5. SEX

MALE

6. RACE

CAUCASIAN

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

DEC. 12, 1893

9. AGE (In years last birthday)

74

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

ASST. CASHIER

10B. KIND OF BUSINESS OR INDUSTRY

STEEL MFGR.

11. BIRTHPLACE (State or foreign country)

PENNA.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ERWIN WIEAND

14. MOTHER'S MAIDEN NAME

CARRIE N. ROEDER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

213/09/3051

17. INFORMANT

C.E. WIEAND

ADDRESS

6103 HAMILTON AVE
BALTO. MD.

18. 412.9 x 185 X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

AS-CV Disease and 10 y mo.
(B) DUE TO, OR AS A CONSEQUENCE OF:
Cerebral Arteriosclerosis - 8 mo.
(C)

422.1 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

CA of Prostate -

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Oct. 10 1960 to Jan. 28 1968, that (I) (we) last saw the deceased alive on Jan 27 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.

23A. SIGNATURE

M. B. Davis M.D.

Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED

1/28/68

23C. PHYSICIAN'S NAME (Type)

M. B. DAVIS M.D.

23D. ADDRESS

6800 MORNINGTON RD. MARYLAND 21222

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

2/1/1968

24C. NAME OF CEMETERY or CREMATORY

TRINITY REFORM

24D. LOCATION

LOWER MILFORD TWP PENNA.

25A. DATE REC'D BY HEALTH DEPT.

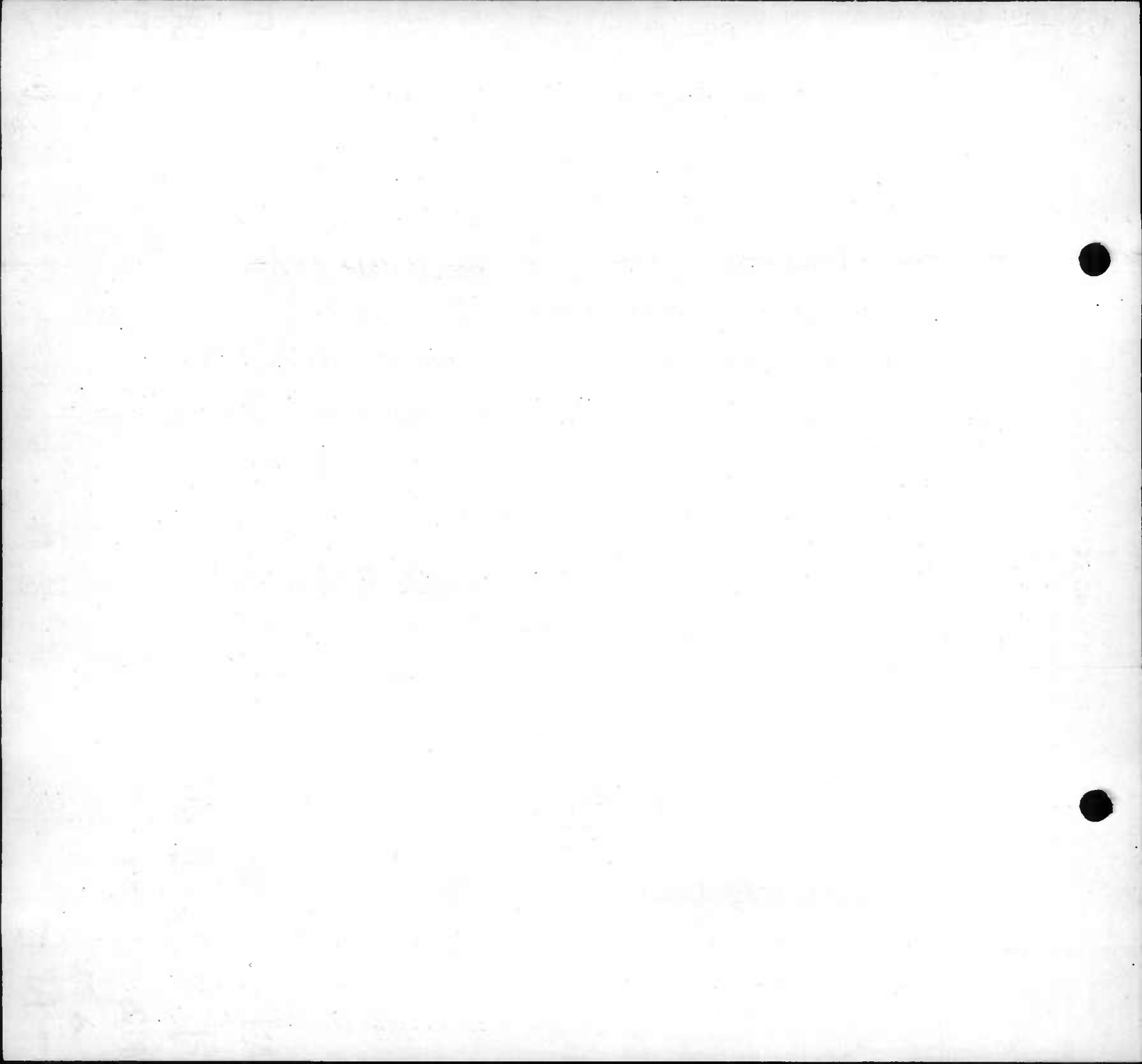
JAN 30 1968

25B. NAME OF REGISTRAR

Robert E. Fisher

25C. FUNERAL DIRECTOR

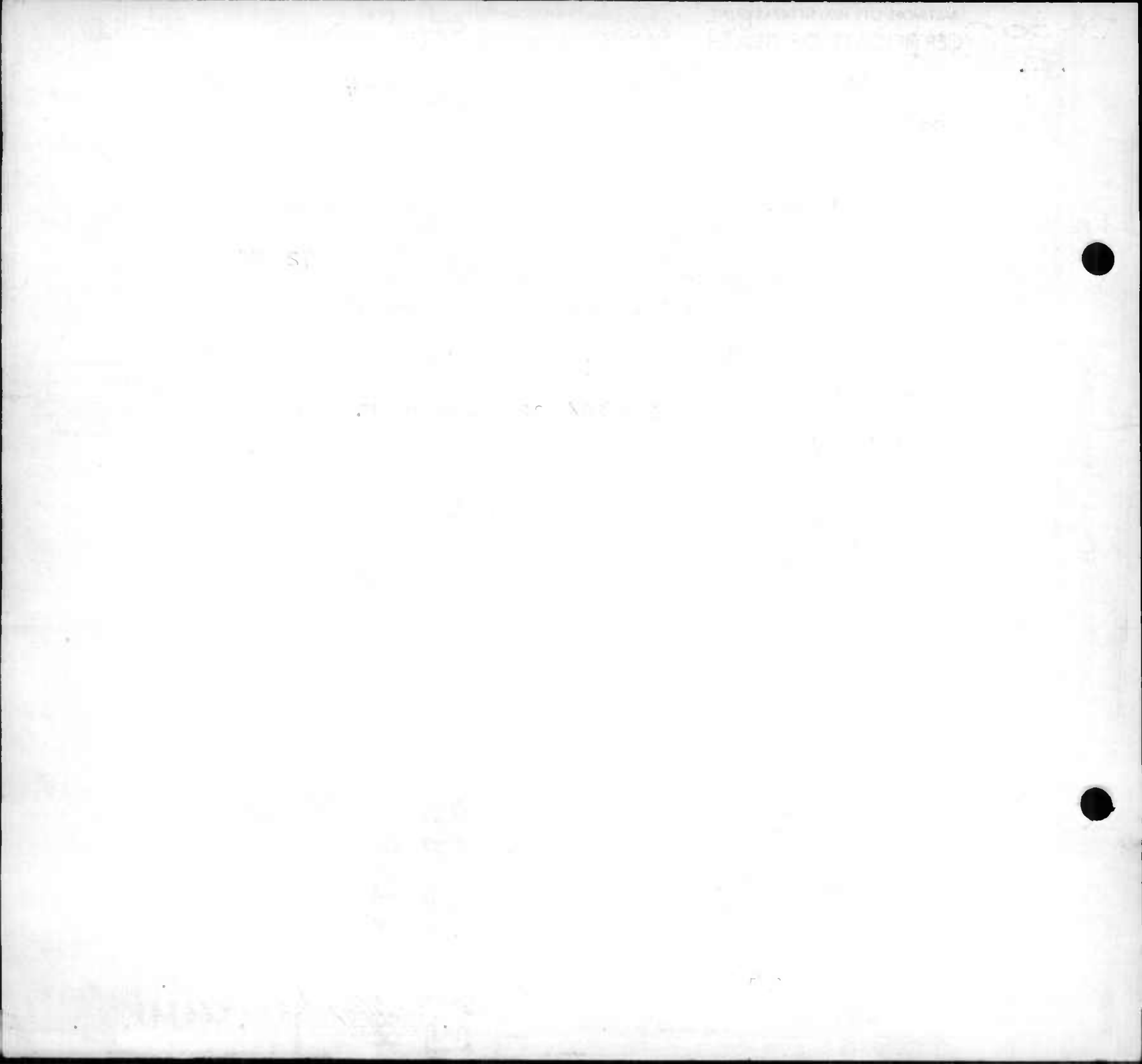
W. Edwin Bradley, Dundalk, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68-1173	
BIRTH NO. 68-1173		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) ** Dunn, Rosina		1/28/68 - 10:45 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND ** ROSINA YEHLE DUNN FULL NAME OF (If not in hospital or institution, give street HOSPITAL OR address or location) INSTITUTION 49 North Charles Gen Hosp.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE 53-00 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balt, MD. 21228 D. STREET ADDRESS (If rural, give location) 2518 Gray Manor Terrace	
5. SEX ♀	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widow	8. DATE OF BIRTH 2-4-95
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY RETAIL SALES	9. AGE (In years last birthday) 72 ##
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM YEHLE		14. MOTHER'S MAIDEN NAME MARY (?)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217/22/6632	
17. INFORMANT FLORENCE B. DUNN		ADDRESS AS IN 4 ABOVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Anemia, Severe G-I bleeding chronic		INTERVAL BETWEEN ONSET AND DEATH	
19. DATE OF OPERATION		20. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-15-1968 to 1-28-1968 that (I) (we) last saw the deceased alive on 1-28-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Elmo M. Gayoso		23B. DATE SIGNED 1/28/68	
23C. PHYSICIAN'S NAME (Type) Elmo M. Gayoso		23D. ADDRESS North Charles Gen Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 2/1/1968	
24C. NAME OF CEMETERY OR CREMATORY MORELAND MEMORIAL		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT. JAN 30 1968		25B. NAME OF REGISTRAR Robert E. Farber	
25C. FUNERAL DIRECTOR W. Brooks Bradley		ADDRESS BUNDALK, MD.	



H-425

68-1174 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-1174

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GERALDINE HOLCOMB		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> January 24, 1968 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour January 25, 1968 1:05 A.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
9. DATE OF BIRTH SEPT. 20, 1927		10. AGE (In years last birthday) 40	
11. BIRTHPLACE (State or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSEPH SHIFFLETT		14. STREET AND NUMBER 88 Poplar Road	
15. MOTHER'S MAIDEN NAME ?		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. 219-20-9898		18. INFORMANT STANLEY HOLCOMB	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Myocarditis ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 422.2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ABOVE	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED January 25, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/29/68	
24C. NAME OF CEMETERY or CREMATORY BELAIR MEM.		24D. LOCATION (City, town, or county) (State) HARFORD MD.	
25A. DATE REC'D BY HEALTH DEPT. JAN 30 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR J.G. CONNELLY SONS		ADDRESS 300 MACE	

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1863. It is a very important document, as it contains the President's annual message to Congress. The letter is written in a formal, dignified style, and it is one of the most important documents in the history of the United States.

2. The second part of the document is a report from the Secretary of the Treasury, dated January 1, 1863. It is a very important document, as it contains the Secretary's annual report to Congress. The report is written in a formal, dignified style, and it is one of the most important documents in the history of the United States.

3. The third part of the document is a report from the Secretary of the Interior, dated January 1, 1863. It is a very important document, as it contains the Secretary's annual report to Congress. The report is written in a formal, dignified style, and it is one of the most important documents in the history of the United States.

4. The fourth part of the document is a report from the Secretary of the War, dated January 1, 1863. It is a very important document, as it contains the Secretary's annual report to Congress. The report is written in a formal, dignified style, and it is one of the most important documents in the history of the United States.

5. The fifth part of the document is a report from the Secretary of the Navy, dated January 1, 1863. It is a very important document, as it contains the Secretary's annual report to Congress. The report is written in a formal, dignified style, and it is one of the most important documents in the history of the United States.

6. The sixth part of the document is a report from the Secretary of the State, dated January 1, 1863. It is a very important document, as it contains the Secretary's annual report to Congress. The report is written in a formal, dignified style, and it is one of the most important documents in the history of the United States.

7. The seventh part of the document is a report from the Secretary of the War, dated January 1, 1863. It is a very important document, as it contains the Secretary's annual report to Congress. The report is written in a formal, dignified style, and it is one of the most important documents in the history of the United States.

8. The eighth part of the document is a report from the Secretary of the Navy, dated January 1, 1863. It is a very important document, as it contains the Secretary's annual report to Congress. The report is written in a formal, dignified style, and it is one of the most important documents in the history of the United States.

9. The ninth part of the document is a report from the Secretary of the State, dated January 1, 1863. It is a very important document, as it contains the Secretary's annual report to Congress. The report is written in a formal, dignified style, and it is one of the most important documents in the history of the United States.

10. The tenth part of the document is a report from the Secretary of the War, dated January 1, 1863. It is a very important document, as it contains the Secretary's annual report to Congress. The report is written in a formal, dignified style, and it is one of the most important documents in the history of the United States.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
68- 1175 CERTIFICATE OF DEATH					Registered No. 68- 1175				
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
CRAMBLITT, MYRTLE ELIZABETH					JANUARY 28, 1968 5:25P M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST AGNES HOSPITAL WILKENS & CATON AVE. BALTIMORE, MARYLAND 21229					A. STATE MD. 21229 23-02				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				
D. STREET ADDRESS (If rural, give location) 1222 PATAPSCO STREET									
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 12-22-90	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Joseph Wagner					14. MOTHER'S MAIDEN NAME HARTMAN, MARY				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 213-01-1849		17. INFORMANT ADDRESS ST AGNES RECORDS WILKENS & CATON AVES				
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) Acute coronary thrombosis DUE TO (B) A.S.C.U.D. DUE TO (C)				
INTERVAL BETWEEN ONSET AND DEATH									
420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (X) (this hospital) attended the deceased from JANUARY 26, 19 68 to JANUARY 28, 19 68, that (X) (we) lost saw the deceased alive on JANUARY 28, 19 68 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.									
23A. SIGNATURE Alejandro Mejia					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) ALEJANDRO MEJIA					23D. ADDRESS M.D. WILKENS & CATON AVES. BALTO; MD. 21229				
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR			ADDRESS	
JAN 30 1968			Robert E. Finkbeiner		McCurly - 130 E. Fort Ave.				

12:22

12:22

12:22

12:22

12:22

12:22

12:22

12:22

12:22

12:22

12:22

12:22

12:22

12:22

12:22

12:22

12:22

12:22

12:22

12:22

12:22

12:22

12:22

12:22

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1176

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-1176

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Curley, William J.

2. DATE AND HOUR OF DEATH

1-28-68 10:55 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)
A. STATE B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1408 Belt St.

5. SEX

Male

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

6-22-1902

9. AGE (In years last birthday)

65

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Longshoreman

10B. KIND OF BUSINESS OR INDUSTRY

Shipyard

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Joseph T. Curley

14. MOTHER'S MAIDEN NAME

Anna Clark

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

217-09-1168

17. INFORMANT

ADDRESS

Mrs. Anna V. Curley, 1408 Belt St. Balto. 30

18.

519.9 I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

Right Side Heart failure

10 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

Cor pulmonale

(C) CHRONIC OBSTRUCTIVE AIRWAY DISEASE

MEDICAL CERTIFICATION

527.2 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 26 19 68 to Jan 28 19 68, that (I) (we) last saw the deceased alive on Jan 28 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Sang Yoon Rhim

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

Jan 28 '68

23C. PHYSICIAN'S NAME (Type)

Sang Yoon RHIM

23D. ADDRESS

South Balt. General Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1-31-68

24C. NAME OF CEMETERY or CREMATORY

Most Holy Redeemer Cemetery

24D. LOCATION (City, town, or county) (State)

4430 Belair Rd. Balto. Md. 21206

25A. DATE RECEIVED BY HEALTH DEPT.

JAN 30 1968

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

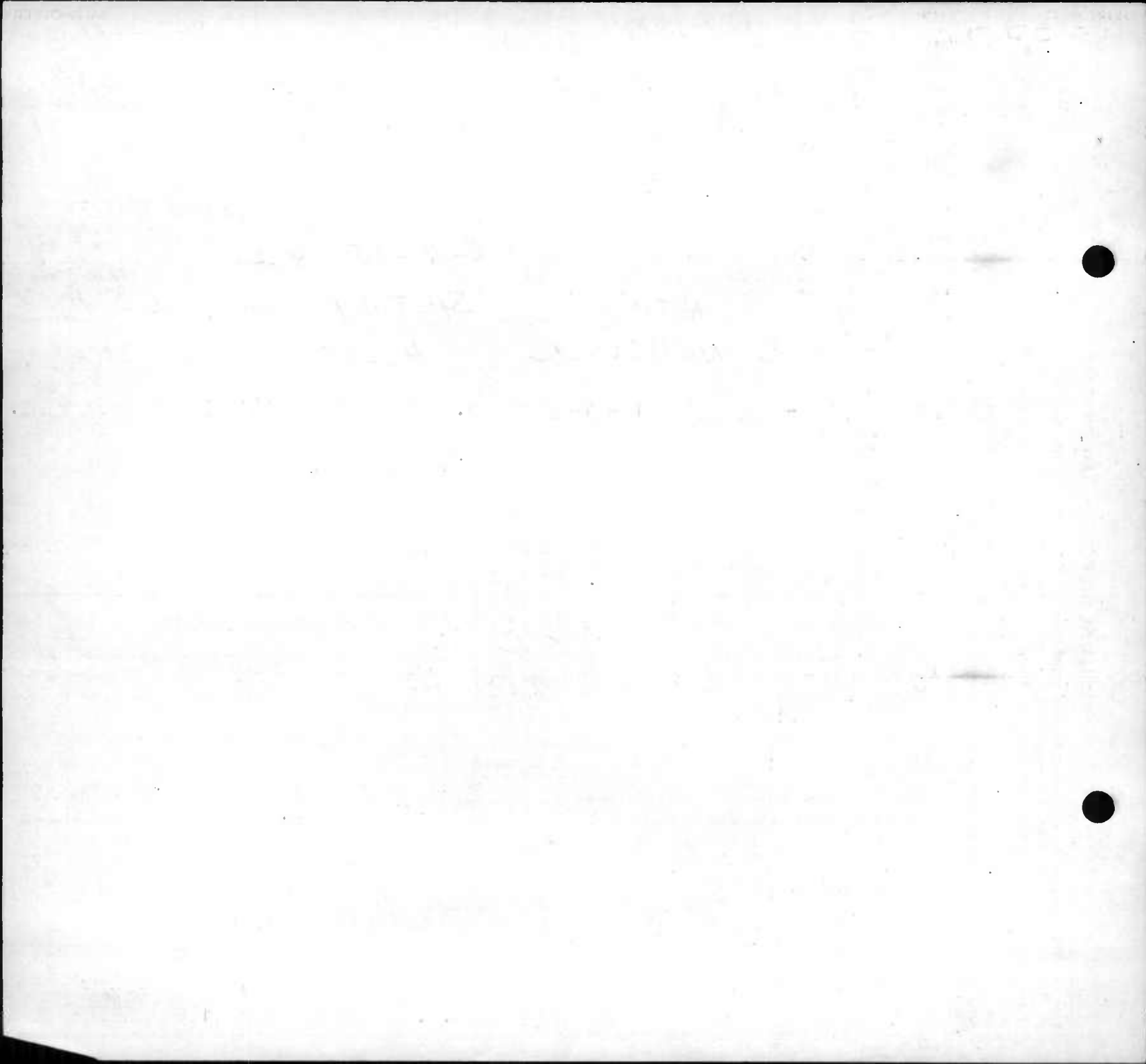
Flynn & Fleming, 1422 Light St., Balto. Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 68-1177			
1. NAME OF DECEASED (Type or Print) JOSEPH C. NIEDZWICK				2. DATE AND HOUR OF DEATH 25 Jan 68 4 35 P.M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 Mercy Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1-04 C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 830 S. LUZERNE AVE							
5. SEX M		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-21-85		9. AGE (In years last birthday) 82		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bottler				10B. KIND OF BUSINESS OR INDUSTRY RETIRED				11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CASIMIR NIEDZWICK				14. MOTHER'S MAIDEN NAME HELEN KUČINSKA							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-01-9302A		17. INFORMANT Mr. Casimir Niedzwick, 7705 Wynbrook Rd.				ADDRESS	
18. 486X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II 493X OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Intermittent Atrial Fibrillation				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that he (this hospital) attended the deceased from 20 Jan 1968 to 25 Jan 1968 , that he (we) last saw the deceased alive on 25 Jan 1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. he (We) (did) (did not) view the body after death.											
23A. SIGNATURE Salvatore R. Donohue				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 25 Jan 68			
23C. PHYSICIAN'S NAME (Type) SALVATORE R. DONOHUE				23D. ADDRESS MERCY HOSP.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 1/29/68				24C. NAME OF CEMETERY or CREMATORY Holy Rosary			
24D. LOCATION Baltimore, Maryland											
25A. DATE REC'D BY HEALTH DEPT. JAN 30 1968				25B. NAME OF REGISTRAR Robert E. Felsky				25C. FUNERAL DIRECTOR ADDRESS M.F. SADOWSKI & SONS, 1808 EASTERN AVE.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.			
1. NAME OF DECEASED (Type or Print) FAIRBANKS MR ERNEST W				2. DATE AND HOUR OF DEATH 1-27-68				7-15 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY USA				27-05			
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME AND HOSPITAL				C. CITY OR TOWN BALTIMORE				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35				E. STREET AND NUMBER 4115 Northern-Pkwy East (6)							
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-10-88	9. AGE (In years last birthday) 79	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) thermal worker				10B. KIND OF BUSINESS OR INDUSTRY Gas & Electric Co.				11. BIRTHPLACE (State or foreign country) MD Baltimore			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME JOHN N. Fairbanks				14. MOTHER'S MAIDEN NAME house callenberg			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW1				16. SOCIAL SECURITY NO. 212-05-6496				17. INFORMANT wife			
18. 491X I				CAUSE OF DEATH				ADDRESS 4115 Northern Pkwy East (6)			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE chronic obstructive pulmonary disease, chronic bronchitis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: pneumonia, USHD, CCH, Cancer larynx							
(C) 502.1 II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1-26 19 68 to 1-27 19 68 , that (I) (we) last saw the deceased alive on 1-27 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Rodolfo M. Lian				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 1-27-68			
23C. PHYSICIAN'S NAME (Type) Rodolfo M. Lian				23D. ADDRESS Church Home & Hosp.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 1-30-1968				24C. NAME OF CEMETERY or CREMATORY Lorraine Cemetery			
24D. LOCATION Baltimore				24E. STATE Md.							
25A. DATE REC'D BY HEALTH DEPT. JAN 30 1968				25B. NAME OF REGISTRAR Robert E. Fairbanks				25C. FUNERAL DIRECTOR Lassahn Funeral Home 2140 Belden Rd			

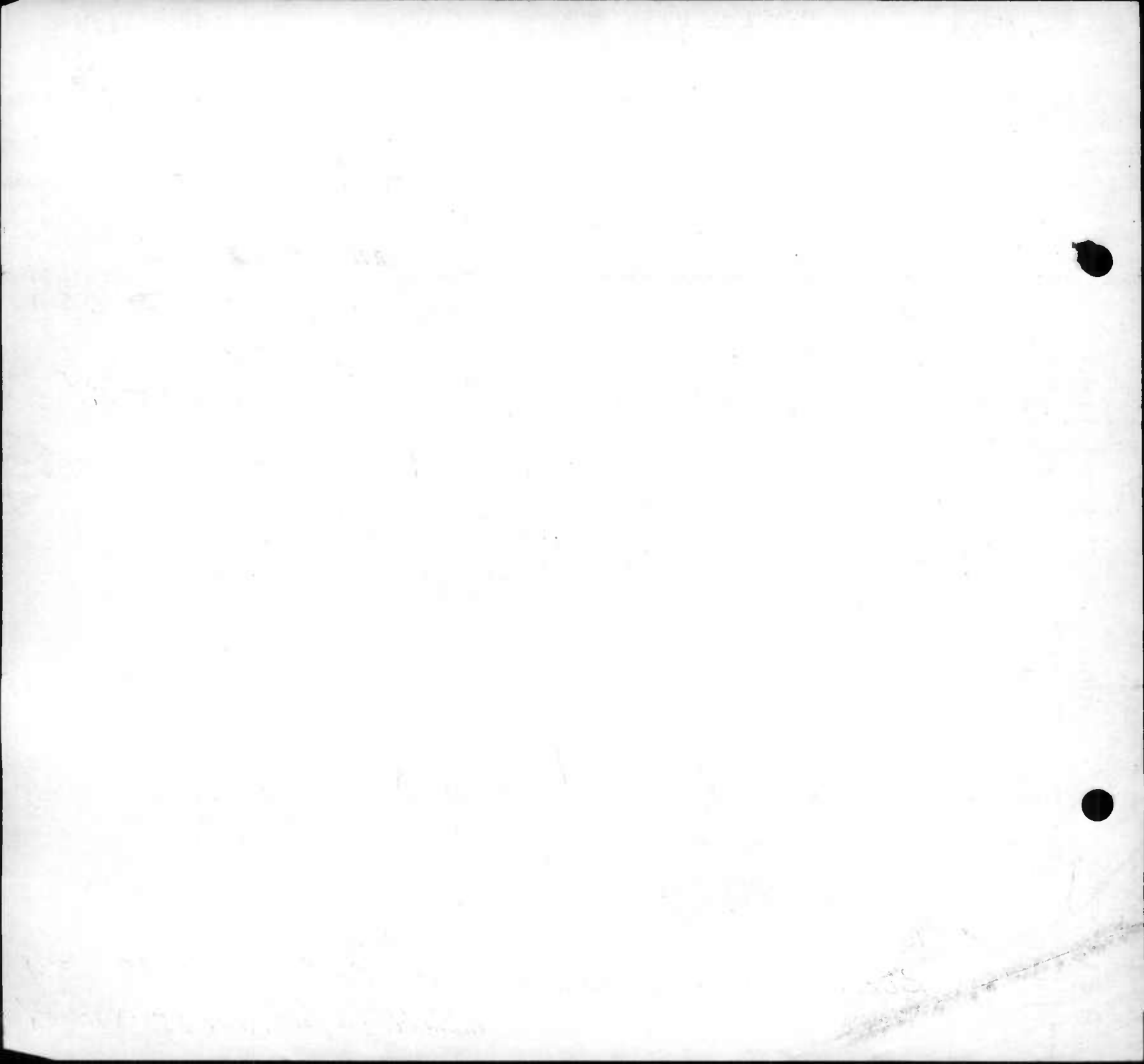
Charles M. Smith
Charles M. Smith

Charles M. Smith

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1179
BIRTH NO. 68-1179		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>MRS PAULINE WILLING</u>		2. DATE AND HOUR OF DEATH <u>2:10 AM 1/23/68</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>48 MGH</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>53-00</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 MGH</u>		C. CITY OR TOWN <u>BALTO. Co.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>F</u>		6. RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>77</u>
13. FATHER'S NAME <u>RALPH WILLING</u>		14. MOTHER'S MAIDEN NAME <u>Lettie O. L. Phand-</u>		11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>220-12-7192</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
17. INFORMANT <u>Ralph E. Willing</u>		ADDRESS <u>410 Hopkins Rd</u>		
18. <u>422.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>PULMONARY EMBOLUS.</u> (B) <u>ASCRD</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>CONGESTIVE HEART FAILURE.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>42 PRO</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>422.1 II</u>				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from <u>1/13</u> 19 <u>68</u> to <u>1/23</u> 19 <u>68</u> , that (1) (we) last saw the deceased alive on <u>1/23</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Ann R. Wilke MD</u>		DEGREE <u>MD</u>		23B. DATE SIGNED <u>1/23/68</u>
23C. PHYSICIAN'S NAME (Type) <u>Ann R. Wilke MD</u>		23D. ADDRESS <u>MGH</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1/26/1968</u>		24C. NAME OF CEMETERY or CREMATORY <u>Moreland Memorial</u>
24D. LOCATION (City, town, or county) (State) <u>Balto Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 30 1968</u>		
25B. NAME OF REGISTRAR <u>R. E. Faldum</u>		25C. FUNERAL DIRECTOR <u>Mitchell-Wiede-feld Home</u>		
ADDRESS <u>6500 York Rd</u>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

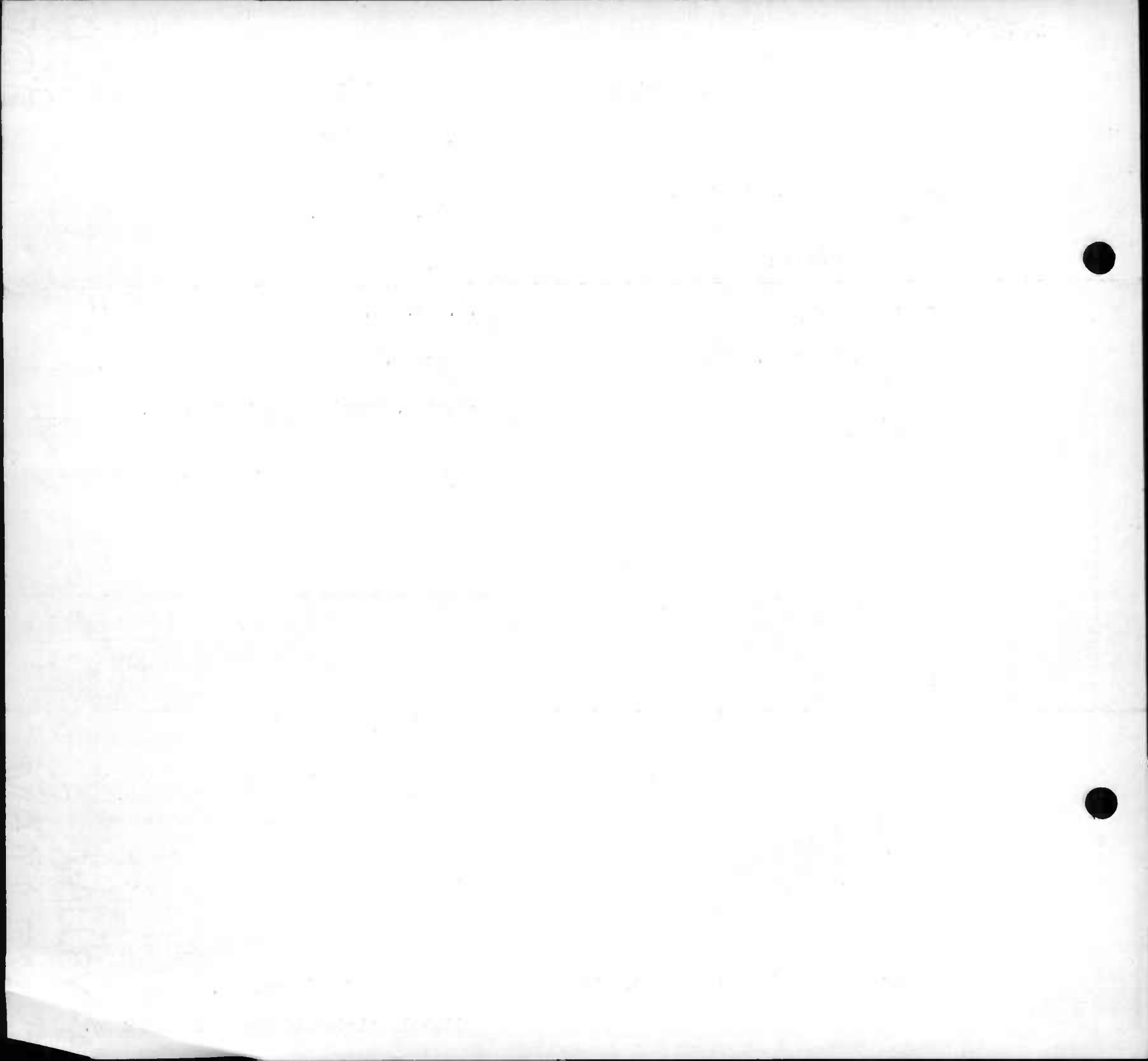
68-1180

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-1180

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Maud S. Carrigan		1/26/1968 11:30 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
00 730 St. Johns Rd.				Md. Baltimore	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				730 St. Johns Rd.	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Female	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	May 26, 1898	69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Retired Sect.			A.A. Co. Md.		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Rev. Henry R. Savage			Lucy O. Chaney		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
NO			218 28 1399		Robert S. Carrigan Abington, Md.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
CAUSE OF DEATH					
410.9 I Myocardial Infarction 48 hrs					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-26-68 to 1-26-68, that (I) (we) last saw the deceased alive on 1-26-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
[Signature]				1-29-68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1/29/1968		Mt. Olivet	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 30 1968		Robert E. Tarkenton		Mitchell Wiedefeld Home 6500 York Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 1181	
68- 1181				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Katherine V Logan</i>		2. DATE AND HOUR OF DEATH <i>1/25/1968</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i> <i>53-00</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Towson</i>	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <i>301 W. Chesapeake Ave</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4 4- 1883</i>	9. AGE (In years last birthday) <i>84</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Teacher</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Ashland, Md.</i>	
13. FATHER'S NAME <i>Luke Logan</i>		14. MOTHER'S MAIDEN NAME <i>Bridgett Healy</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>213 48 7093</i>		17. INFORMANT <i>John E. Logan</i> ADDRESS <i>5103 Springlake Way</i>	
18. <i>4-12-94-182.0</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>CHF w/ actual fibrillation</i> DUE TO, OR AS A CONSEQUENCE OF: <i>2 mos.</i> (B) <i>ACVD w/ coronary insufficiency</i> DUE TO, OR AS A CONSEQUENCE OF: <i>50 years</i> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>420.1 II</i>		19A. DATE OF OPERATION <i>0 none</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) <i>NO</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>December 13 19 67</i> to <i>January 25 19 68</i> , that (I) (we) last saw the deceased alive on <i>Jan 25 19 68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i>		23B. DATE SIGNED <i>1-25-68</i>		23C. PHYSICIAN'S NAME (Type) <i>[Signature]</i>	
23D. ADDRESS <i>Mercy Hospital Calvert St.</i>		23E. DATE SIGNED <i>1-25-68</i>		23F. PHYSICIAN'S NAME (Type) <i>[Signature]</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>2/1/1968</i>		24C. NAME OF CEMETERY or CREMATORY <i>St. Joseph Cemetery</i>	
24D. LOCATION <i>Texas,</i>		24E. CITY, TOWN, or county <i>Md.</i>		24F. STATE <i>Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 30 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Mitchell-Wiedefeld Home</i> ADDRESS <i>6500 York Rd.</i>	

1000

1000

1000

1000

1000

1000

X

1000

B-300

68-1182 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-1182

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HARRY E. BOYD		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> January 29, 1968 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) DeSoto 00 1701 DeSoto Road 21230		3. DATE PRONOUNCED DEAD Month Day Year Hour January 29, 1968 1:55 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 25-52	
9. DATE OF BIRTH 10/11/91		10. AGE (In years last birthday) 76 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Colorado		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationery Engineer		14B. KIND OF BUSINESS OR INDUSTRY Beth. Shipbuilding	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		17. SOCIAL SECURITY NO. 215-05-5276	
15. MOTHER'S MAIDEN NAME Jennie Herron		18. INFORMANT ADDRESS Mrs. Nellie M. Boyd, 1701 DeSoto Rd., 21230	
19. 412.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II 423.1 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED January 29, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/31/68	
24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 30 1968		25B. NAME OF REGISTRAR Dr. H. E. Johnson	
25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS	

Page 1

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 68-1183	
BIRTH NO. 68-1183		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LARSON, MARY MAUDE		2. DATE AND HOUR OF DEATH JANUARY 28, 1968 6:35P.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore		5.3-00	
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MD. 21229		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE - 21229		D. STREET ADDRESS (If rural, give location) 4300 43 HIGHVIEW AVE.	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 06-06-92	9. AGE (In years last birthday) 75	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE Retired		10B. KIND OF BUSINESS OR INDUSTRY Cashier		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN S. CURLE		14. MOTHER'S MAIDEN NAME PAULINE Gause Gause	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 101-1X6-1893		17. INFORMANT BALTO., MD. 21229	
18. 153.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Metastatic Adenocarcinoma, Intestine DUE TO (B) Cerebral Arteriosclerosis DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 153.9 II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from DECEMBER 20 1967 to JANUARY 28 1968 , that (I) (we) last saw the deceased alive on JANUARY 28 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Romualdo R. Dator				23B. DATE SIGNED 01-28-68	
23C. PHYSICIAN'S NAME (Type) Romualdo R. Dator		23D. ADDRESS WILKENS & CATON AVE. - BALTO. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/31/68		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 30 1968		25B. NAME OF REGISTRAR Robert E. Farber	
25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS			

• • •

STANDARD FORM NO. 64-581-101

- 10 -

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1 S-162		68-1184		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1184	
CERTIFICATE OF DEATH							
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Michael c. Sperko		2. DATE AND HOUR OF DEATH Jan. 28, 1968		9:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 205 CHOPTANK AVE			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-1-12	9. AGE (In years last birthday) 56	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam fitter		10B. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ALBERT SPERKO				14. MOTHER'S MAIDEN NAME MARY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 193-07-6674		17. INFORMANT Mrs. Mary Sperko ADDRESS 205 Choptank Avenue			
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Metastatic bronchogenic carcinoma		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: carcinoma				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 months	
18. 162.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:				(C) DUE TO, OR AS A CONSEQUENCE OF:	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from Jan. 21 19 68 to Jan. 28 19 68 , that (1) (we) lost saw the deceased alive on Jan. 28 19 68 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (Did) (did not) view the body after death.							
23A. SIGNATURE John D. Graber				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Jan. 28, 1968	
23C. PHYSICIAN'S NAME (Type) John D. Graber				23D. ADDRESS Johns Hopkins Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-1-1968		24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 30 1968		25B. NAME OF REGISTRAR John D. Graber		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68-1185		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68-1185	
<p align="center">CERTIFICATE OF DEATH</p>					
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Wanda S. O'Reilly (Carmine)		2. DATE AND HOUR OF DEATH 1-26-68 7:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2401 Eutaw Place			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 6/2/05	9. AGE (In years last birthday) 62	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Michael Dongowski			14. MOTHER'S MAIDEN NAME Catherine Turkowski		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-16-5139		17. INFORMANT ADDRESS Melvin J. Carmine 5532 Cedonia Avenue	
18. 146.0 I		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) Severe intra-oral hemorrhage 10 min			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(B) Tumor invasion carotid artery 1-2 months			
ANTECEDENT CAUSES		(C) Squamous cancer, tonsil 6-8 months			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
145.0 II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED No		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-22-68 to 1-26-68 , that (I) (we) last saw the deceased alive on 1-26-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Leon C Parks MD				23B. DATE SIGNED 1-26-68	
23C. PHYSICIAN'S NAME (Type) Leon C Parks				23D. ADDRESS The Johns Hopkins Hosp	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-30-1968		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus	
24D. LOCATION (City, town, or county) (State) Balt, Md 21205		25A. DATE REC'D BY HEALTH DEPT. JAN 30 1968			
25B. NAME OF REGISTRAR Robert E. Feltz		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave.			

24

7-520

68- 1186 BALTIMORE CITY HEALTH DEPARTMENT

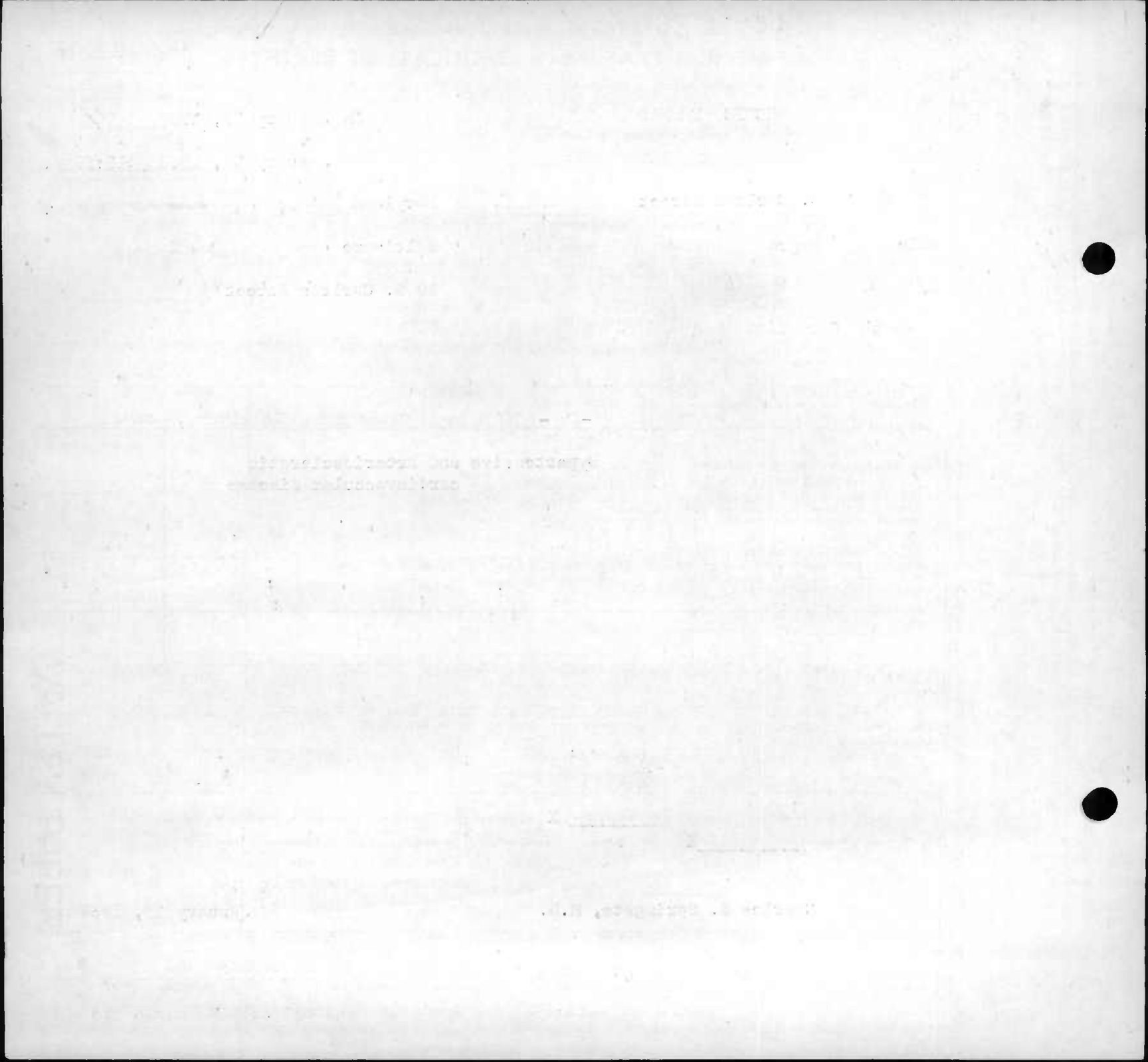
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 1186

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ARCHIE THOMAS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> January 29, 1968 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 20 S. Carlton Street		3. DATE PRONOUNCED DEAD Month Day Year Hour January 29, 1968 12:59 AM	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 1/12/04		10. AGE (In years lost birthday) 64	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stevedore		14B. KIND OF BUSINESS OR INDUSTRY Old Bayline	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 217 -09 -5347	
15. MOTHER'S MAIDEN NAME ?		18. INFORMANT Mrs Catherine Tolliver, same	
19. 412.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertensive and arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 443X II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: cardiovascular disease	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) No	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED January 29, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/1/68	
24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A A County Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 30 1968		25B. NAME OF REGISTRAR Robert E. Farkas	
25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1187

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 1187

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Colbert P. Briscoe

2. DATE AND HOUR OF DEATH

1-23-68

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 1213 Mosher St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

1213 Mosher St.

5. SEX

Male

6. RACE

Negroid

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

5-8- 93

9. AGE (In years
last birthday)

74

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert Briscoe

14. MOTHER'S MAIDEN NAME

Eliza Barnes

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

216-091918

17. INFORMANT

Rosa E. Smith

ADDRESS

same

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

CARDIO VASCULAR

1958

(B) DUE TO, OR AS A CONSEQUENCE OF:

ARTERIO SCLEROSIS

1958

(C) DUE TO, OR AS A CONSEQUENCE OF:

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 19 to 19
that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

E. William Frey

DEGREE

Attending
Phys. ☒

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

1/26/68

23C. PHYSICIAN'S
NAME (Type)

E. WILLIAM FREY MD

DEGREE

23D. ADDRESS

1928 PENNA AVE MD

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1-31-68

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cem.

24D. LOCATION

Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 30 1968

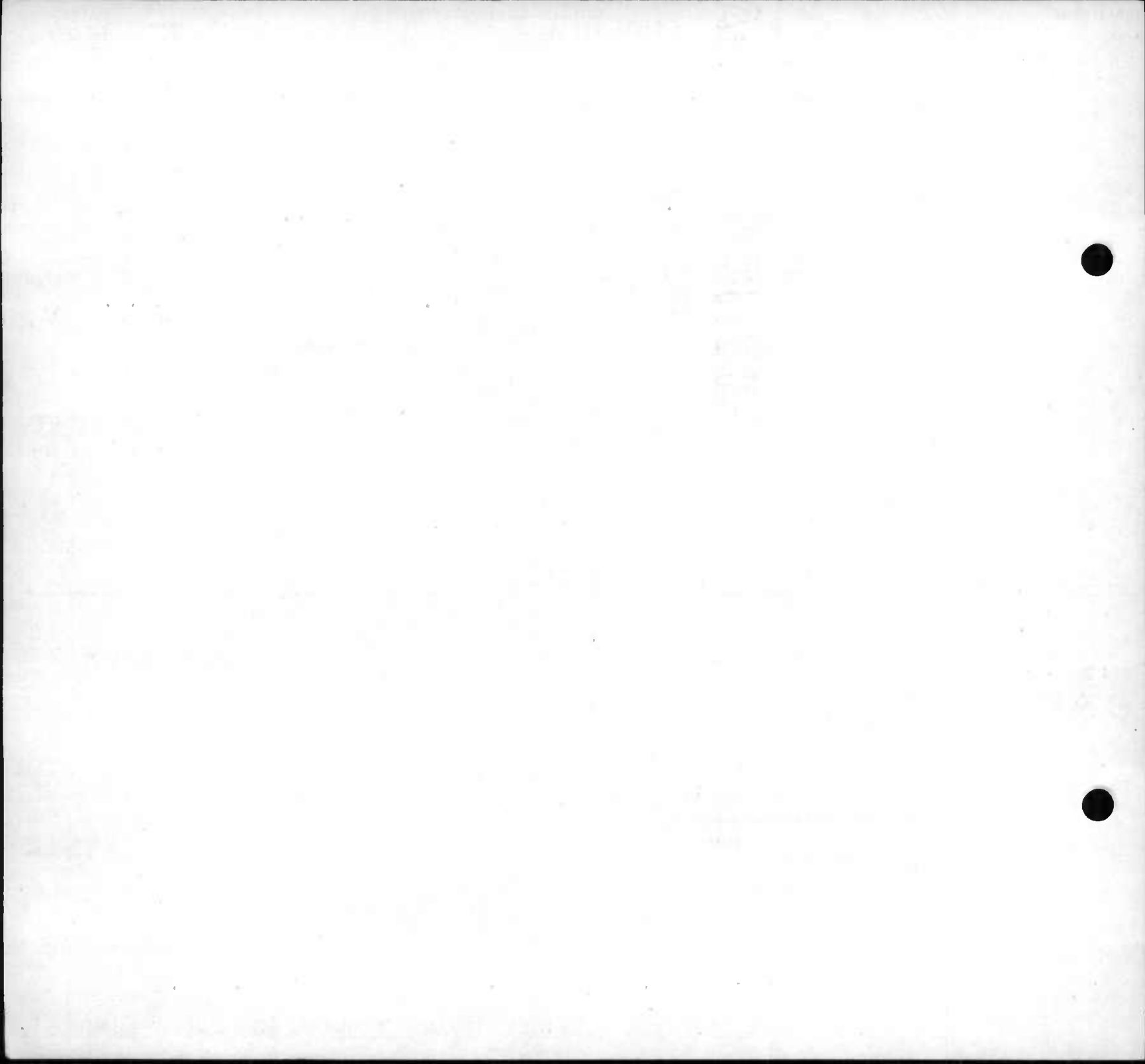
25B. NAME OF REGISTRAR

R. B. E. F. F.

25C. FUNERAL DIRECTOR

Kelson Funeral Home 1348 Calhoun St.

ADDRESS



1
W-252

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) CHARLIE WASHINGTON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> January 28, 1968 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1131 N. Stricker Street		3. DATE PRONOUNCED DEAD Month Day Year Hour January 28, 1968 2:45 P M.	
5. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Maryland B. COUNTY 1602		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 3-5-96		10. AGE (In years lost birthday) 71 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME		13. FATHER'S NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes		17. SOCIAL SECURITY NO. 220239875	
18. INFORMANT Sadie Ellison ADDRESS 724 N. Gilmore St.		19. 412.91 CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 422.1 II			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED January 29, 1968 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-1-68	
24C. NAME of CEMETERY or CREMATORY Balto. Nat'l. Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 30 1968		25B. NAME OF REGISTRAR Robert E. Finkbeiner	
25C. FUNERAL DIRECTOR Nelson Funeral Home		ADDRESS 1348 Calhoun St.	

RECEIVED

1911

1911

1911

WILLIS

1911

1911

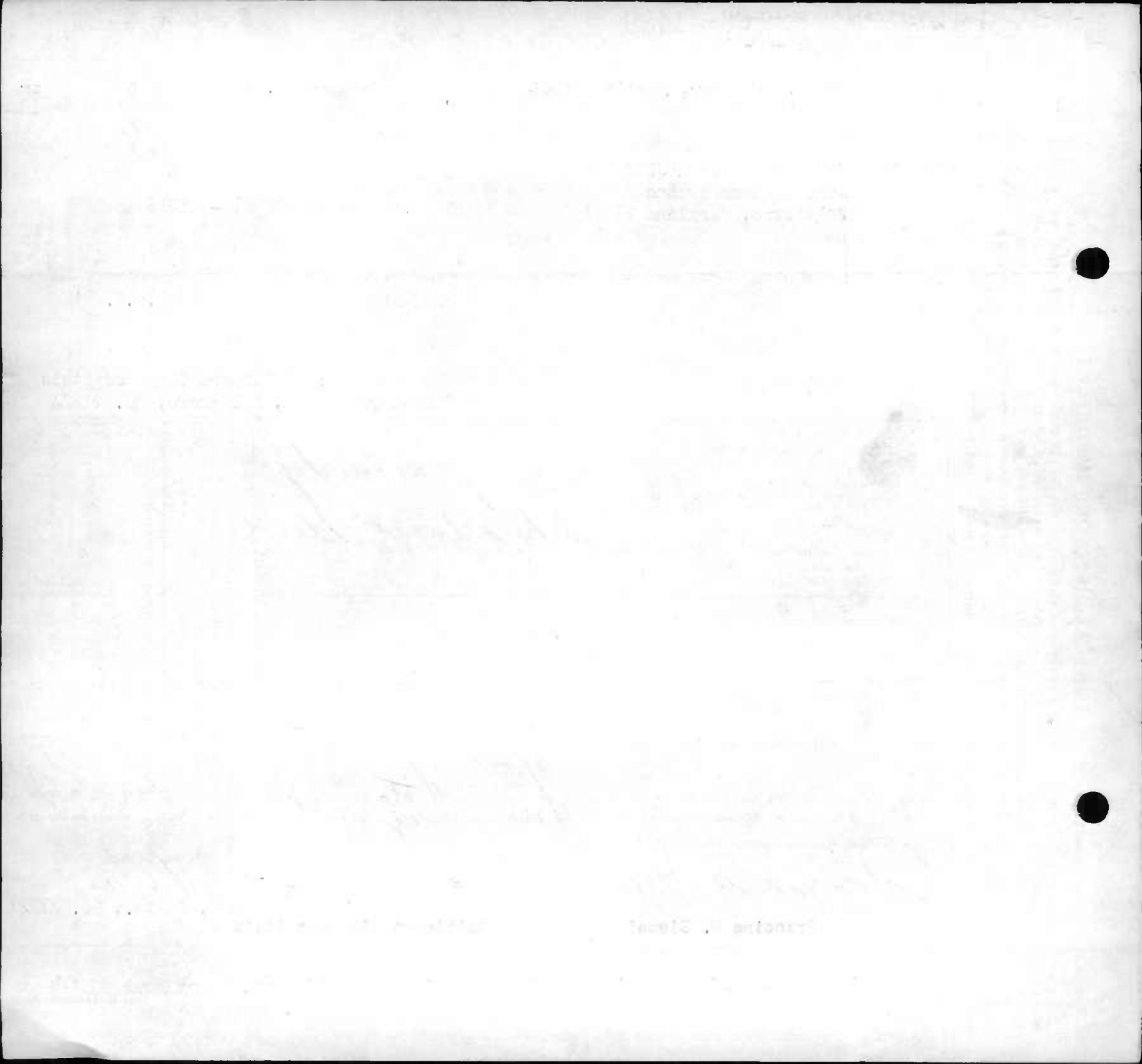
1911

1911

1911

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

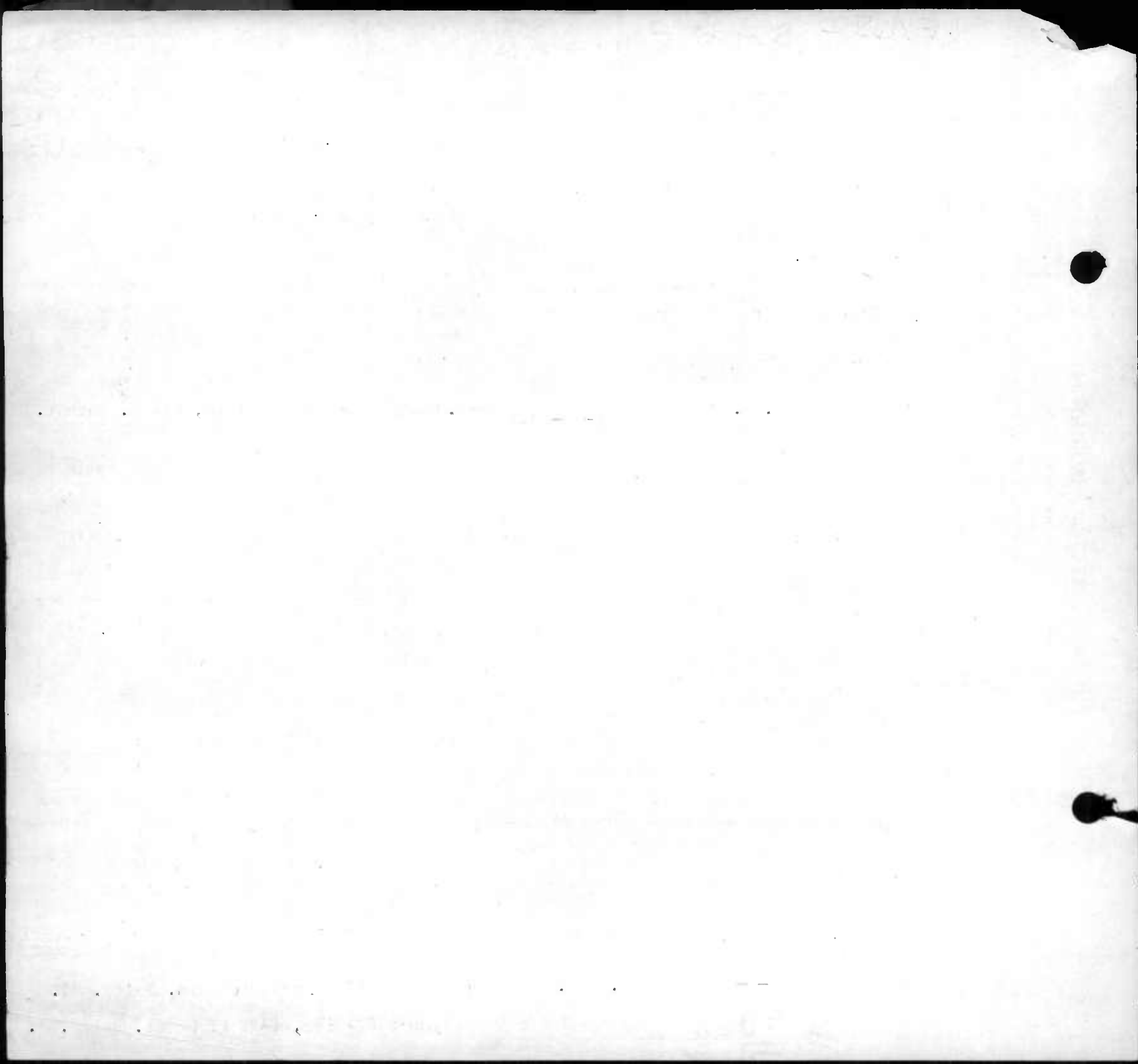
D-530 68-1189		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1189	
BIRTH NO. 68-0156		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Dent, Baby Boy, Corliss Ethel			2. DATE AND HOUR OF DEATH January 26, 1968 6 am		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 832 N. BENTALOU STREET - 21216		
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/26/68	9. AGE (In years last birthday) 4 55	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME UNKNOWN			14. MOTHER'S MAIDEN NAME CORLISS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT RECORDS: Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224		
18. 772.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 760.3 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: prematurity (B) Subarachnoid bleed DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/26/68 19 68 to 1/26/68 19 68 , that (I) (we) last saw the deceased alive on 1/26/68 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Francine M. Siegal, MD			23B. DATE SIGNED 1/26/68		23C. PHYSICIAN'S NAME (Type) Francine M. Siegal
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 1-26-68		24C. NAME OF CEMETERY or CREMATORY Baltimore City Hospitals Baltimore, Maryland 21224	
25A. DATE REC'D BY HEALTH DEPT. JAN 30 1968		25B. NAME OF REGISTRAR Robert E. Siegel		25C. FUNERAL DIRECTOR ADDRESS HOSPITAL DISPOSAL	



FUNERAL DIRECTOR: IMPORTANT

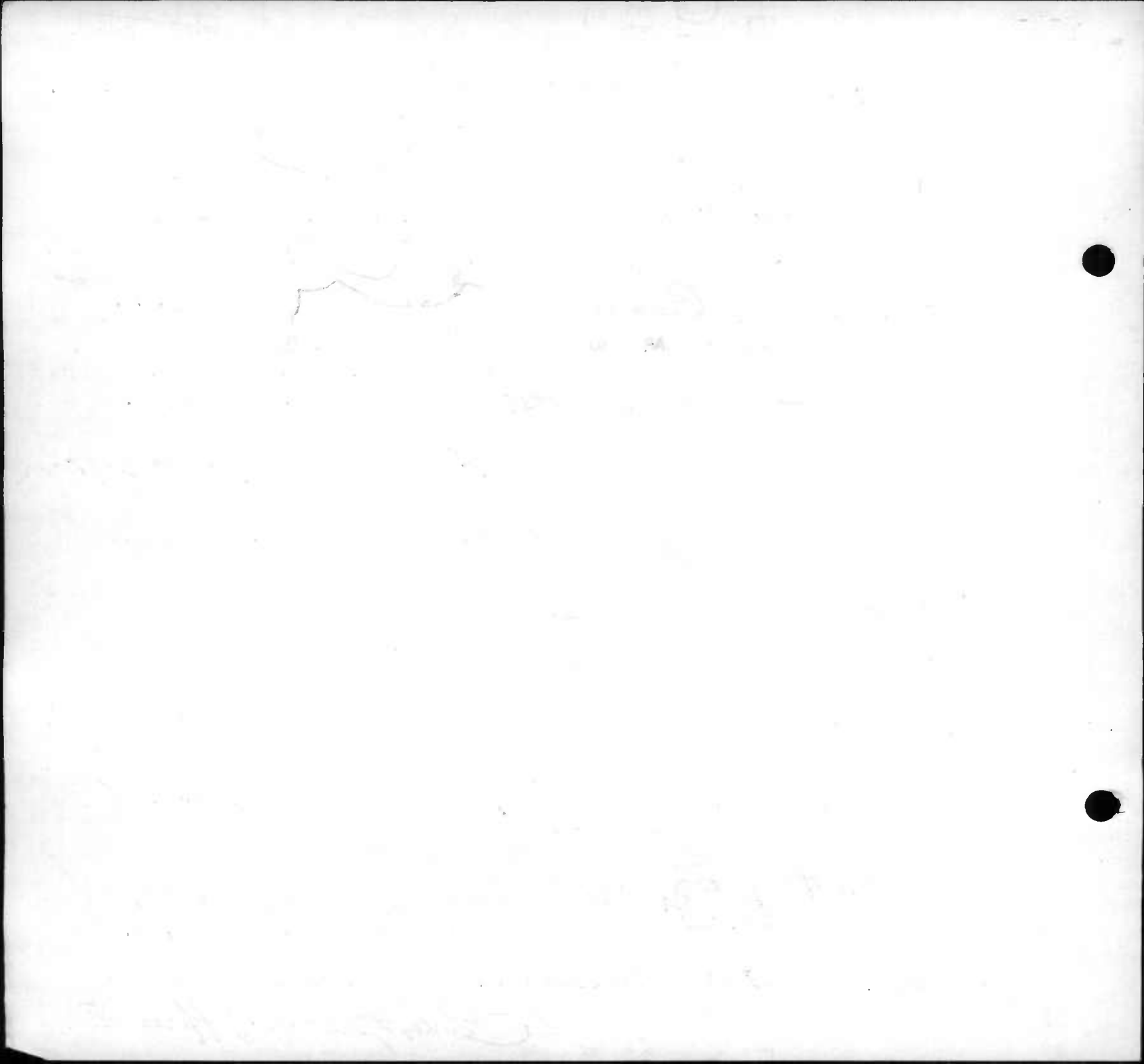
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-652		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1190
68-1190		CERTIFICATE OF DEATH		68-1190
BIRTH NO.		1. NAME OF DECEASED (Type or Print) LAWRENCE FRANKEN FIELD		2. DATE AND HOUR OF DEATH 1-28-68 3:25 P.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		21-02
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY OF MARYLAND Hospital		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX M 6. RACE N 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 4-22-17 9. AGE (In years lost birthday) 50		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN Driver		10B. KIND OF BUSINESS OR INDUSTRY Trucking		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA
13. FATHER'S NAME Theodore FRANKEN FIELD		14. MOTHER'S MAIDEN NAME OLIVE SUTTON		12. CITIZEN OF WHAT COUNTRY? WA.
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN W. W. 2		16. SOCIAL SECURITY NO. UNKNOWN 205-03-6245		17. INFORMANT ADDRESS Mrs. Annabelle Frankenfield, 914 E. 36th St.
18. 571.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) HEPATIC FAILURE		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) NUTRITIONAL cirrhosis DUE TO, OR AS A CONSEQUENCE OF:		UNKNOWN
(C) _____				
19. 581.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CHRONIC PANCREATITIS				UNKNOWN
19A. DATE OF OPERATION 11-17-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Closure of RUPTURE OF Uterus		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (N) (this hospital) attended the deceased from JANUARY 2 19 68 to JANUARY 28 19 68 , that (W) (we) lost saw the deceased alive on JANUARY 28 19 68 and that in (O) (our) opinion death occurred on the date and hour and from the causes stated above. (W) (We) (did) (not) view the body after death.				
23A. SIGNATURE James F. Stoddard MD.		23B. DATE SIGNED 1-28-68		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) JAMES F. STODDARD MD.		23D. ADDRESS SURGERY DEPT UNIVERSITY Md. Hospital.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-1-68		24C. NAME OF CEMETERY OR CREMATORY Balto. Nat. Cemetery
24D. LOCATION (City, town, or county) (State) 5501 Frederick Ave. Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 30 1968		
25B. NAME OF REGISTRAR R. E. E. E.		25C. FUNERAL DIRECTOR ADDRESS Flynn & Fleming, 1422 Light St. Balto. Md.		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>39-72-89] H-220 68-1191</p> <p style="text-align: center;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;">CERTIFICATE OF DEATH</p> <p style="text-align: right;">REG. NO. 668-1191</p>			
<p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) <i>Hughes, Margaret. C.</i></p>		<p>2. DATE AND HOUR OF DEATH</p> <p><i>1/25/68 8:30 P. M.</i></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>16. SOCIAL SECURITY NO. <i>215 01 8737</i></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <i>MARYLAND</i> B. COUNTY <i>6-02</i></p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><i>31</i> BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224</p>		<p>C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <i>2405 E. JEFFERSON STREET - 21205</i></p>	
<p>5. SEX FEMALE</p>	<p>6. RACE WHITE</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <i>7/21/03</i> 9. AGE (In years last birthday) <i>64</i></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>BASTER</i></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY <i>CLOTHING</i></p>	
<p>11. BIRTHPLACE (State or foreign country) MARYLAND</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>	
<p>13. FATHER'S NAME SCHAECH, HARRY W.</p>		<p>14. MOTHER'S MAIDEN NAME SUNDERLAND, MARY B.</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i></p>		<p>17. INFORMANT RECORDS: Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224</p>	
<p>18. <i>182.0 I</i> CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.</p> <p>19. DATE OF OPERATION <i>172X II</i> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> <p>20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> <p>21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)</p> <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p> <p>21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/></p> <p>21F. HOW DID INJURY OCCUR?</p> <p>22. I certify that (I) <i>(initials)</i> attended the deceased from <i>1/21/68</i> 19 to <i>1/25/68</i> 19, that (I) (we) last saw the deceased alive on <i>1/25/68</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> <p>23A. SIGNATURE <i>Robert N. Hill M.D.</i> 23B. DATE SIGNED <i>1/25/68</i></p> <p>23C. PHYSICIAN'S NAME (Type) ROBERT N. HILL 23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224</p> <p>24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> 24B. DATE <i>1-29-68</i> 24C. NAME OF CEMETERY or CREMATORY <i>PARKWOOD Cem.</i> 24D. LOCATION (City, town, or county) (State) <i>BALTO., MD.</i></p> <p>25A. DATE REC'D BY HEALTH DEPT. <i>JAN 30 1968</i> 25B. NAME OF REGISTRAR <i>Robert E. Farber</i> 25C. FUNERAL DIRECTOR <i>Garth Miller - 2334 Jefferson St.</i> ADDRESS</p>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1192

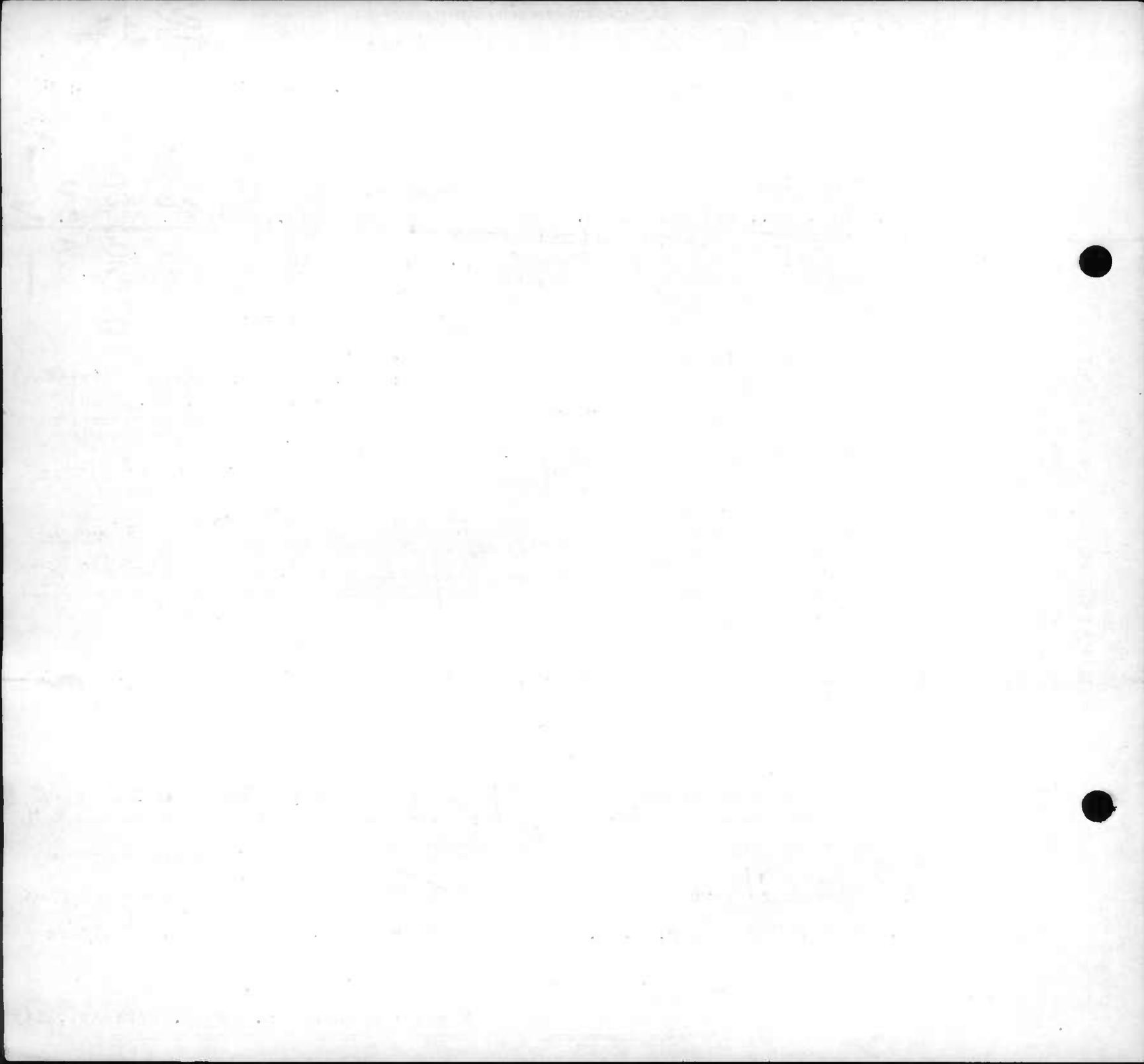
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 01192 192

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ARBOGAST, Pauline		1/25/68 9:05 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
3 The Johns Hopkins Hospital				Maryland Baltimore	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				9 S. Front St.	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9-03-14	53	PACKER
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
PACKER		SEAFOOD		WEST VIRGINIA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Benjamin Smith			Elizabeth		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		218 28 1775		Mrs. Dotie L. Campos - 9 S. Front St.	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
3-83X II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1/19 to 1/25, 1968, that (I) (we) lost saw the deceased alive on 1/25 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Philip R. Reid				1/25/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
PHILIP R. REID				The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		1-29-68		CEDAR HILL Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 30 1968		Robert E. Fisher		Garthley Miller - 2334 Jefferson St.	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 668-11193	
5-315		68-1193		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		PHYLLIS AUSTEN STEPHENS		Jan. 27, 1968 5:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Maryland	
91 " KESWICK "		700 W. 40th. St., Baltimore, Md. 21211		C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		6. RACE		E. STREET AND NUMBER	
Female		White		Marylander Apts., 3501 St. Paul St.	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH	
				Apr. 29, 1887 80	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)	
Retired		Retail Sales		11. BIRTHPLACE (State or foreign country)	
				Near Towson	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John Stokes		Harriet Austen			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT: Mrs. Harry W. Jessop ADDRESS (sister)	
NO		149-22-9211		100 Highland Ave., Towson, Md. 21204	
18. 404X I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Hypertensive Cardio-Vascular		13 years	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE			
ANTECEDENT CAUSES		DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Paralytic Ileus		5 Days	
		(C) Bronchopneumonia		5 Days	
442X II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from April 13 1954 to January 27 1968, that (I) (we) last saw the deceased alive on January 27 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
W. Grafton Hersperger				January 27, 1968	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
W. Grafton Hersperger, M. D.				Keswick - 700 W. 40th Street, Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1/30/68		Green Mount Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 30 1968		Robert E. [Signature]		Stewart & Mowen Co. 108 W. North Av., City	
24D. LOCATION (City, town, or county)		24E. STATE		24F. COUNTY	
Baltimore, Maryland					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

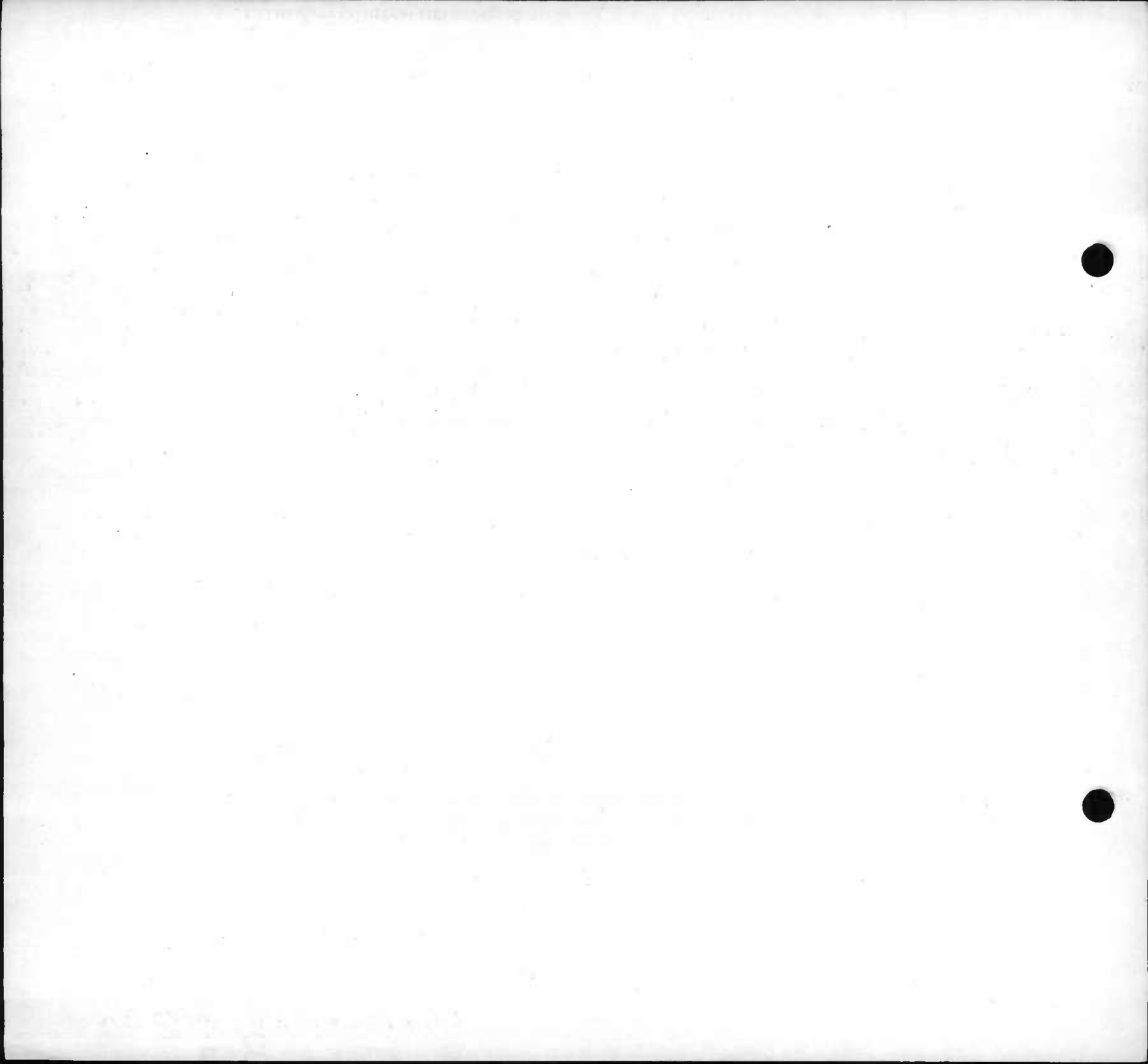
BALTIMORE CITY HEALTH DEPARTMENT									
68-1194 CERTIFICATE OF DEATH					REG. NO. 68-1194				
BIRTH NO. W-652									
1. NAME OF DECEASED (Type or Print) Sister Martha Waring					2. DATE AND HOUR OF DEATH January 27, 1968 2:55 P.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION 93 Villa St. Michael Baltimore, Maryland 21207					A. STATE Maryland B. COUNTY Baltimore City				
					C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
E. STREET AND NUMBER 4000 Forest Hill Road									
5. SEX F.	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-30-1876	9. AGE (In years last birthday) 91	10. Under 1 Yr. Months: Days: Hours: Min.		11. Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired			10B. KIND OF BUSINESS OR INDUSTRY Sister of Charity		11. BIRTHPLACE (State or foreign country) Nottingham, Maryland			12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME William Waring					14. MOTHER'S MAIDEN NAME Ida Julia Brooke				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 219-54-0844		17. INFORMANT Sister Andrea - Villa St. Michael				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4-12-91 219-54-0844 CAUSE OF DEATH Cardio-vascular collapse 14 days					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years (?)				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 422.1 II					20. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: General Arterio-sclerosis (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). None									
19A. DATE OF OPERATION None			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No injury		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from April 1958 to January 1968 , that (I) (we) last saw the deceased alive on January 23, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Damian P. Alagia</i>					23B. DATE SIGNED 1-27-68			Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) Damian P. Alagia, M.D.					23D. ADDRESS 21228 3326 Frederick Avenue, Baltimore, Md. 21				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE JAN. 29/68		24C. NAME of CEMETERY or CREMATORY Seton - on grounds of Seton Inst., Reisterstown Rd., City			24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JAN 30 1968			25B. NAME OF REGISTRAR <i>Robert E. Finkbeiner</i>			25C. FUNERAL DIRECTOR ADDRESS STEWART & MOWEN CO. 108 W. North Av., City 1			

Handwritten signature

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

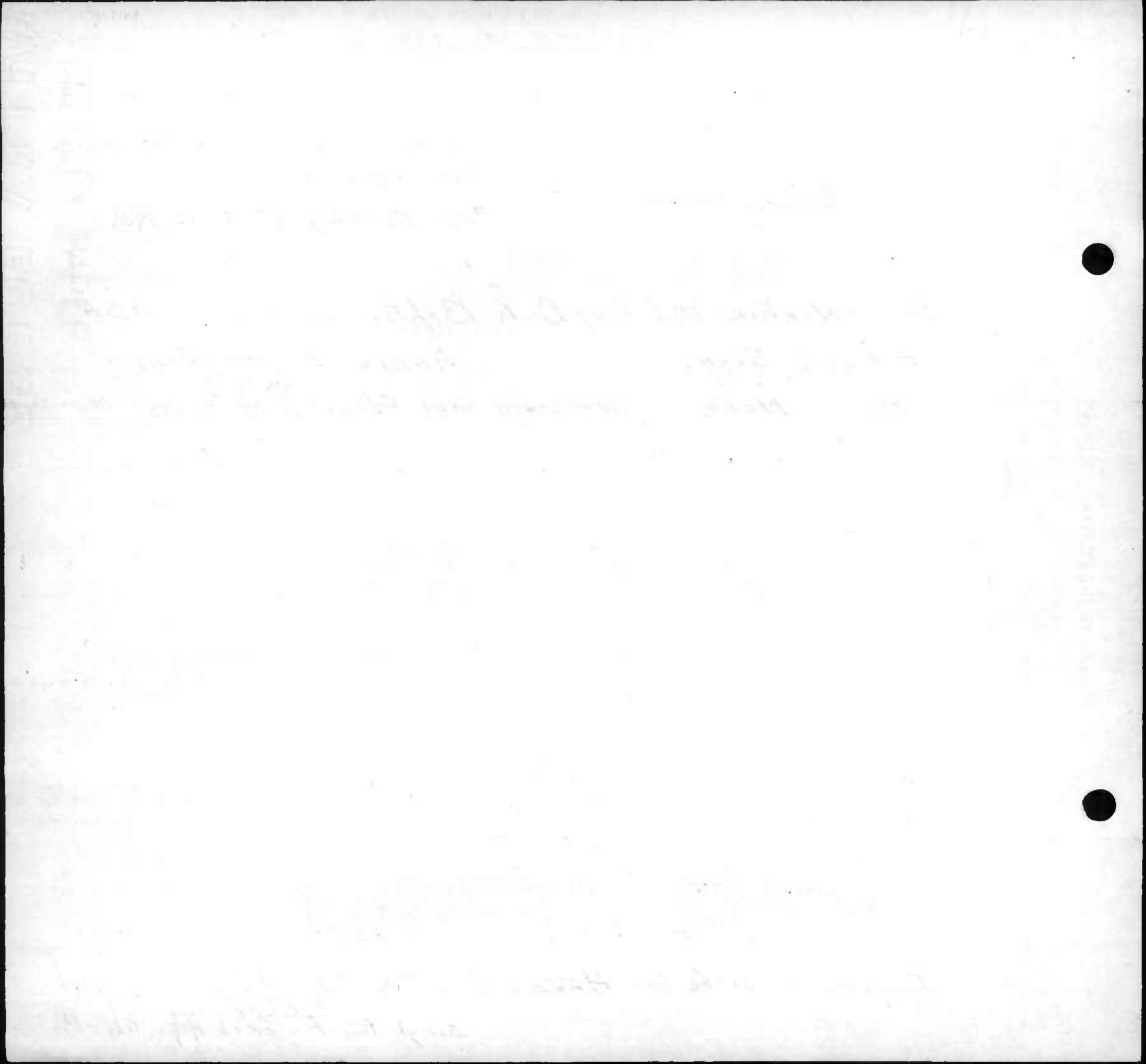
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-1195</u>
B-340		68-1195		CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>DAVID BATTLE</u>		
2. DATE AND HOUR OF DEATH <u>22 JAN 1968</u> <u>4¹⁰</u> A.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>38 University Hospital</u>		
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>19-01</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>1703 Edmondson Ave</u>		5. SEX <u>M</u> 6. RACE <u>N</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <u>11/7/1876</u> 9. AGE (In years last birthday) <u>90</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Melvin Battle</u> ADDRESS <u>418 Mt Holly St</u>
18. <u>195.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia</u> (B) <u>Abdominal Cancer</u> (C) <u>months</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u>
19. <u>199.2 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>20 Jan</u> 19 <u>68</u> to <u>22 Jan</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>22 Jan</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>R. P. Wenzel MD</u>		23B. DATE SIGNED <u>22 Jan '68</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>R. P. WENZEL</u>		23D. ADDRESS <u>University Hospital</u>		
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/30/68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn</u>
24D. LOCATION <u>Baltimore MD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 30 1968</u>		
25B. NAME OF REGISTRAR <u>Robert E. Jarboe</u>		25C. FUNERAL DIRECTOR <u>Charles A. Rice</u> ADDRESS <u>6614 Barre St</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1196	
5-620		68-1196	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Sears, Warren S	
2. DATE AND HOUR OF DEATH 1-28-1968 4:45 AM		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 43 South Baltimore General Hospital	
4. USUAL RESIDENCE (Where deceased lived, if institution: residence, before admission) A. STATE Maryland B. COUNTY Anne Arundel		5. FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hospital	
6. CITY OR TOWN Glen Burnie		7. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
8. STREET AND NUMBER #113 Markey Station Rd		9. AGE (In years last birthday) 63	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Iron-Worker		11. BIRTHPLACE (State or foreign country) Baltimore Md	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Edwin Sears	
14. MOTHER'S MAIDEN NAME Annie E. Hollins		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None	
16. SOCIAL SECURITY NO. 214-03-2131		17. INFORMANT (Wife) MRS Florence V. Sears	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of the lung ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 163 x II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 163 x II		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 months	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED same and bronchopneumonia	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? same and bronchopneumonia	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21D. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21E. HOW DID INJURY OCCUR?		21F. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22. I certify that (I) (his hospital) attended the deceased from 1-23-1968 19 to 1-28 19 '68 , that (I) (we) last saw the deceased alive on 1-28 19 '68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Sang Yoon Rhim		23B. DATE SIGNED Jan 28 '68	
23C. PHYSICIAN'S NAME (Type) Sang Yoon RHIM		23D. ADDRESS South Balt. General Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-31-68	
24C. NAME OF CEMETERY or CREMATORY Glen HAVEN Cemetery		24D. LOCATION (City, town, or county) (State) Glen Burnie, Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 30 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR EB Fleming		25D. ADDRESS Singleton Funeral Home Glen Burnie	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-460		68-1197		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1197	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Rose B. Mullar			
2. DATE AND HOUR OF DEATH 1-27-68				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
4. USUAL RESIDENCE (Where deceased lived/ If institution: residence before admission)				A. STATE MARYLAND , BALTIMORE			
C. CITY OR TOWN Middle River				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER Box 414 Rt. 15 BURKE ROAD				53.00			
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 9-21-86	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 81		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME ANDREW GRYBOS			
14. MOTHER'S MAIDEN NAME ? Waelavik				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 213-12-2220B				17. INFORMANT (Daughter) Md. Mrs. Dolores Cook, Box 414, Rt. 15, Balto.			
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE Cardiac Arrest			
DUE TO, OR AS A CONSEQUENCE OF:				(B) MYOCARDIAL INFARCTION			
DUE TO, OR AS A CONSEQUENCE OF:				(C) ARTERIAL SCLEROTIC VASCULAR DISEASE			
19. DATE OF OPERATION				20A. AUTOPSY? (Yes or No) No			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. HOW DID INJURY OCCUR?				21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				22. I certify that (I) (this hospital) attended the deceased from 1/19 19 68 to 1/27 19 68 , that (I) (we) last saw the deceased alive on 1/27 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Philip Reid				23B. DATE SIGNED 1/27/68			
23C. PHYSICIAN'S NAME (Type) PHILIP REID				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 1/31/68			
24C. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JAN 30 1968				25B. NAME OF REGISTRAR Robert E. Tarkenton			
25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.				ADDRESS			

TO A NEW YORK OFFICE

NY

NY

NEW YORK

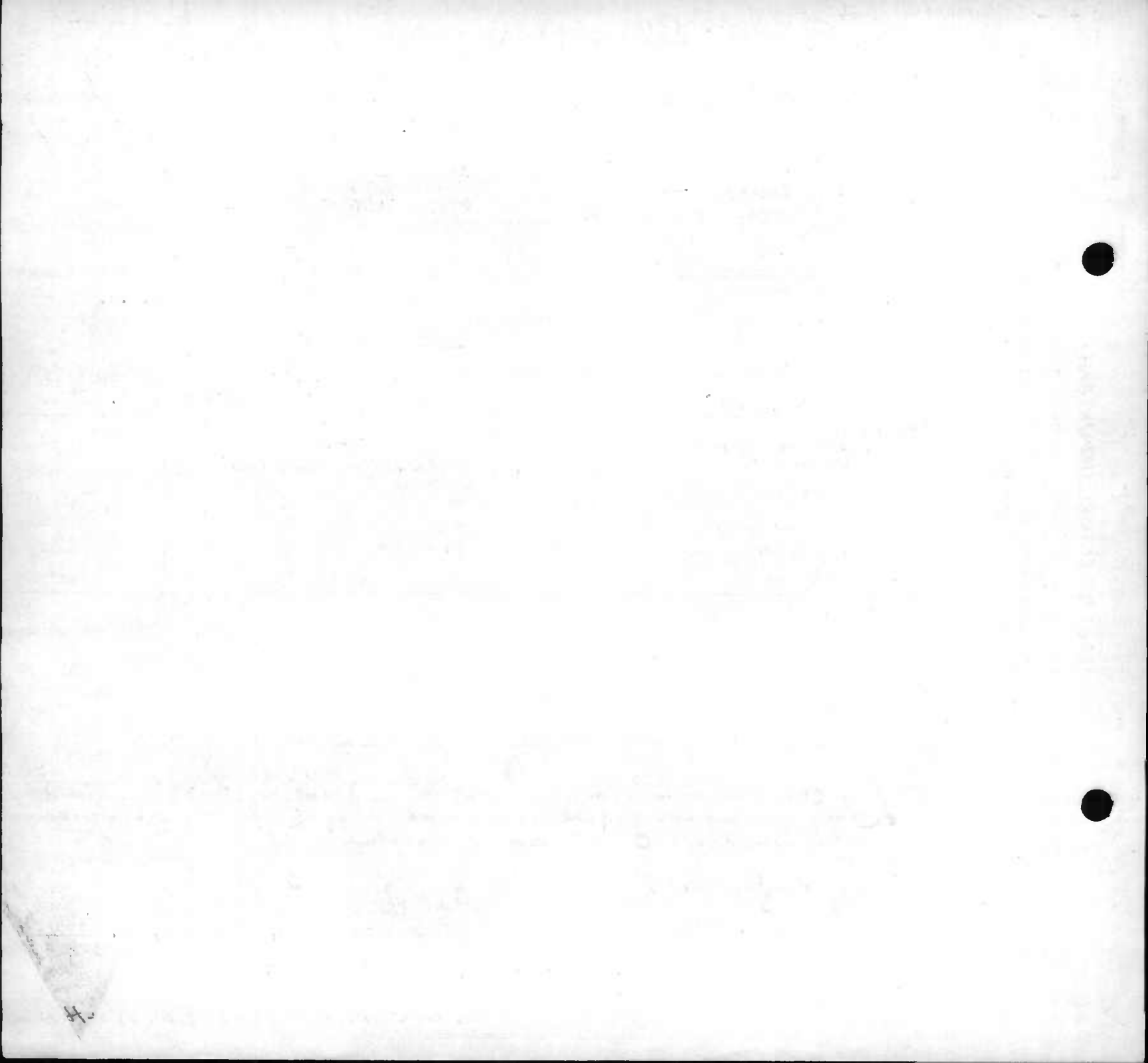
NEW YORK

E

NY

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1198	
1. NAME OF DECEASED (Type or Print) Joseph Turner, Jr.		2. DATE AND HOUR OF DEATH 1-28-68 8 15 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2337 N CALVERT STREET - 21218			
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/3/28	9. AGE (In years last birthday) 39	10. Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOSEPH TURNER		14. MOTHER'S MAIDEN NAME MAUDE DUDDEY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES KOREAN		16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS: Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) PULMONARY TUBERCULOSIS		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from 1-27 19 68 to 1-28 19 68 , that (2) (we) last saw the deceased alive on 1-28 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Leroy E. Kagle		23B. DATE SIGNED 1-28-68			
23C. PHYSICIAN'S NAME (Type) LEROEY E. KAGLE		23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 2-1-68		24C. NAME of CEMETERY or CREMATORY BALTO. NATIONAL CEM.	
24D. LOCATION (City, town, or county) (State) BALTO. Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 30 1968		25B. NAME OF REGISTRAR Robert E. Farley	
25C. FUNERAL DIRECTOR Wm C. MARCH		25D. ADDRESS 928 E. North Ave			



68-1199 CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Davis, Matthew (JR)

2. DATE AND HOUR OF DEATH

1-27-68

4:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

31

BALTIMORE CITY HOSPITALS

4940 EASTERN AVENUE

BALTIMORE, MARYLAND 21224

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1753 MONTPELIER STREET 21218

5. SEX

MALE

6. RACE

NEGRO

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH

4-27-17

9. AGE (in years
last birthday)

50

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

STEEL WORKER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

NORTH CAROLINA

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

MATTHEW DAVIS SR.

14. MOTHER'S MAIDEN NAME

EULA HENDERSON

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

246-10-6731

17. INFORMANT

ADDRESS

RECORDS-BCH-4940 EASTERN AVENUE, BALTIMORE

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last,

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

161X

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

White At ☐
WorkNot White ☐
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-24-1968 to 1-27-1968
that (I) (we) last saw the deceased alive on 1-27-1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S
NAME (Type)

R. P. DESMOND

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

1-27-68

23D. ADDRESS

BCH-4940 EASTERN AVENUE-BALTIMORE, MD. 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

2/3/68

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

HENDERSON, N.C.

25A. DATE REC'D BY HEALTH DEPT.

JAN 30 1968

25B. NAME OF REGISTRAR

J. E. JONES

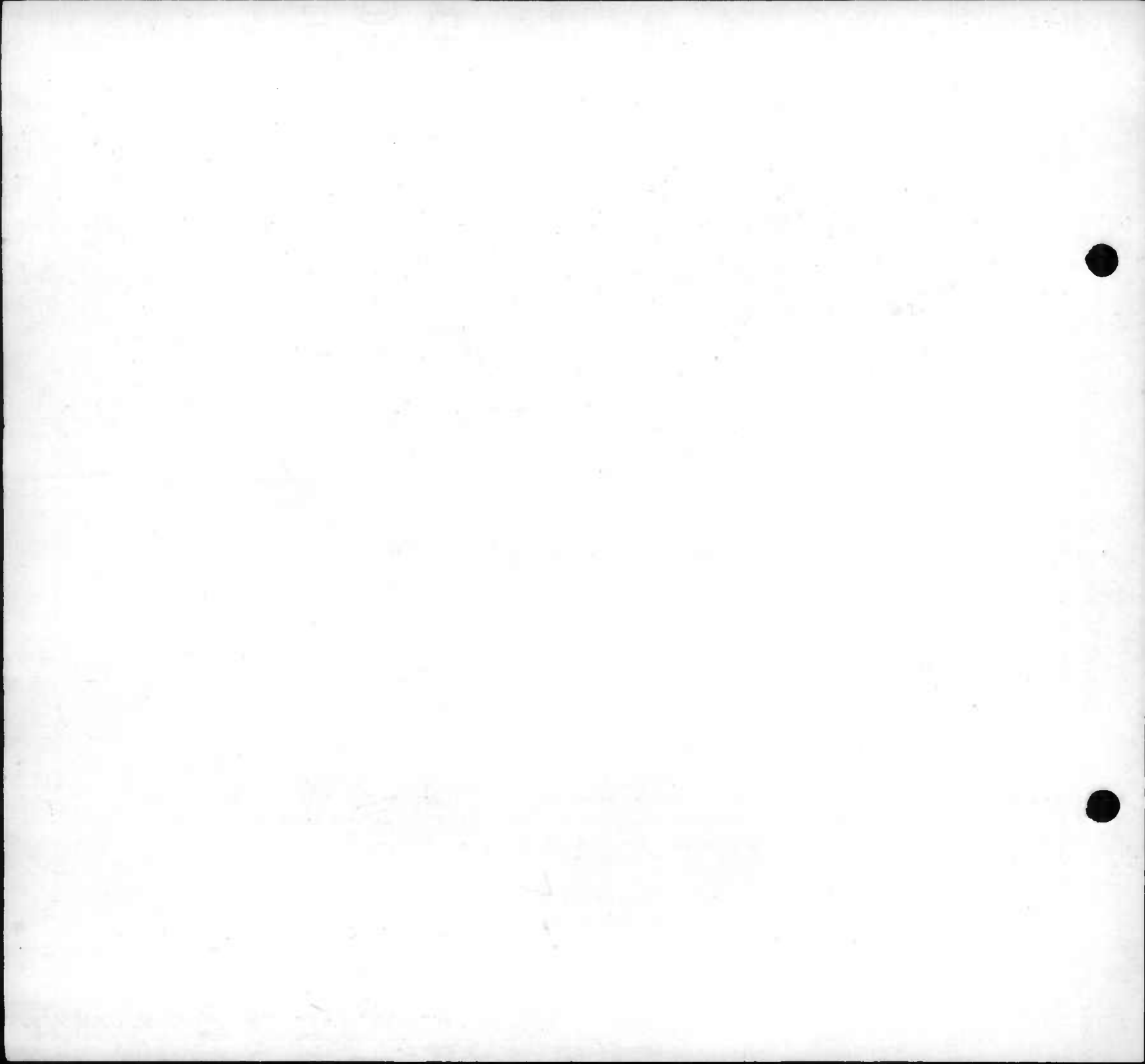
25C. FUNERAL DIRECTOR

ADDRESS

WM. C. MARCH 928 E. NORTH AVE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1200

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-1200

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOHNNY BRANHAM

2. DATE AND HOUR OF DEATH

1-27-68

6-15 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

16 Lutheran Hospital, Balto.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD.

A.G.C.

3200

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

4018 Annapolis Rd.

5. SEX

M

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

8-7-79

9. AGE (In years
last birthday)

88

If Under 1 Yr.

Months: Days

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Buggy BRANHAM

14. MOTHER'S MAIDEN NAME

MILLIE ROBERTS

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

231-16-9648

17. INFORMANT

PEACEY BRANHAM-912 JACK ST.

ADDRESS

18.

492 X I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Bronchopneumonia 9 days

(B) DUE TO, OR AS A CONSEQUENCE OF:

Chronic pulmonary Emphysema + 20 years

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

527.1 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED

20A. AUTOPSY? (Yes or No)

☒

20B. IF YES, WERE FINDINGS CONSIDERED

IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME

(Month) (Day) (Year) (Hour)

OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-18-1968 to 1-27-1968,
that (I) (we) lost saw the deceased alive on 1-27-1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Zakaudin Vera

Attending
Phys. ☐

Med.
Director ☐

Staff
Phys. ☒

23B. DATE SIGNED

1-27-68

23C. PHYSICIAN'S
NAME (Type)

ZAKAUDIN VERA

23D. ADDRESS

Lutheran Hospital.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1/30/68

24C. NAME of CEMETERY or CREMATORY

Glen Haven Cemetery

24D. LOCATION

Glen Burnie, Md.

(City, town, or county)

(State)

25A. DATE RECEIVED BY HEALTH DEPT.

JAN 31 1968

25B. NAME OF REGISTRAR

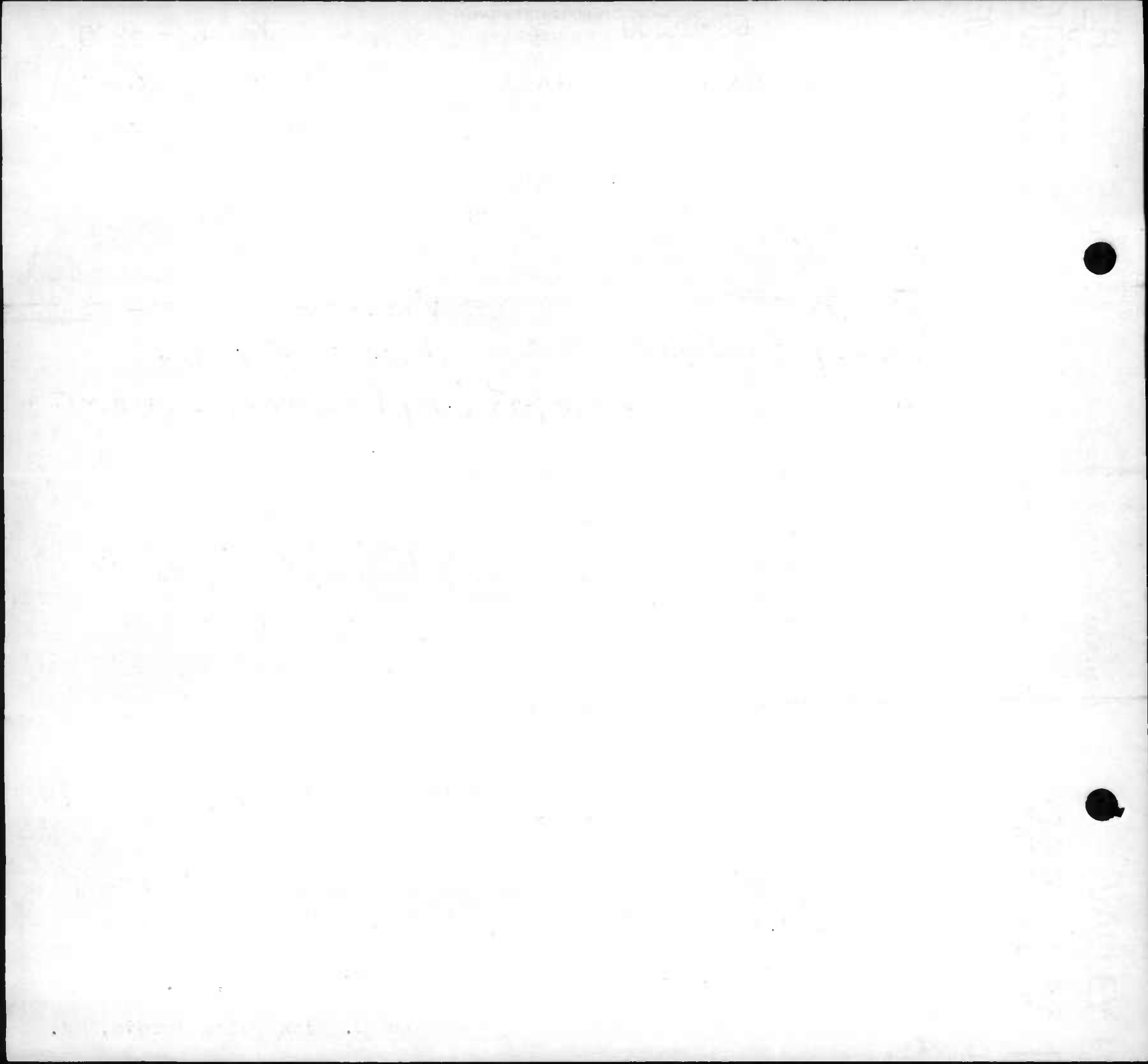
Robert E. Farber

25C. FUNERAL DIRECTOR

Raymond C. Fink

ADDRESS

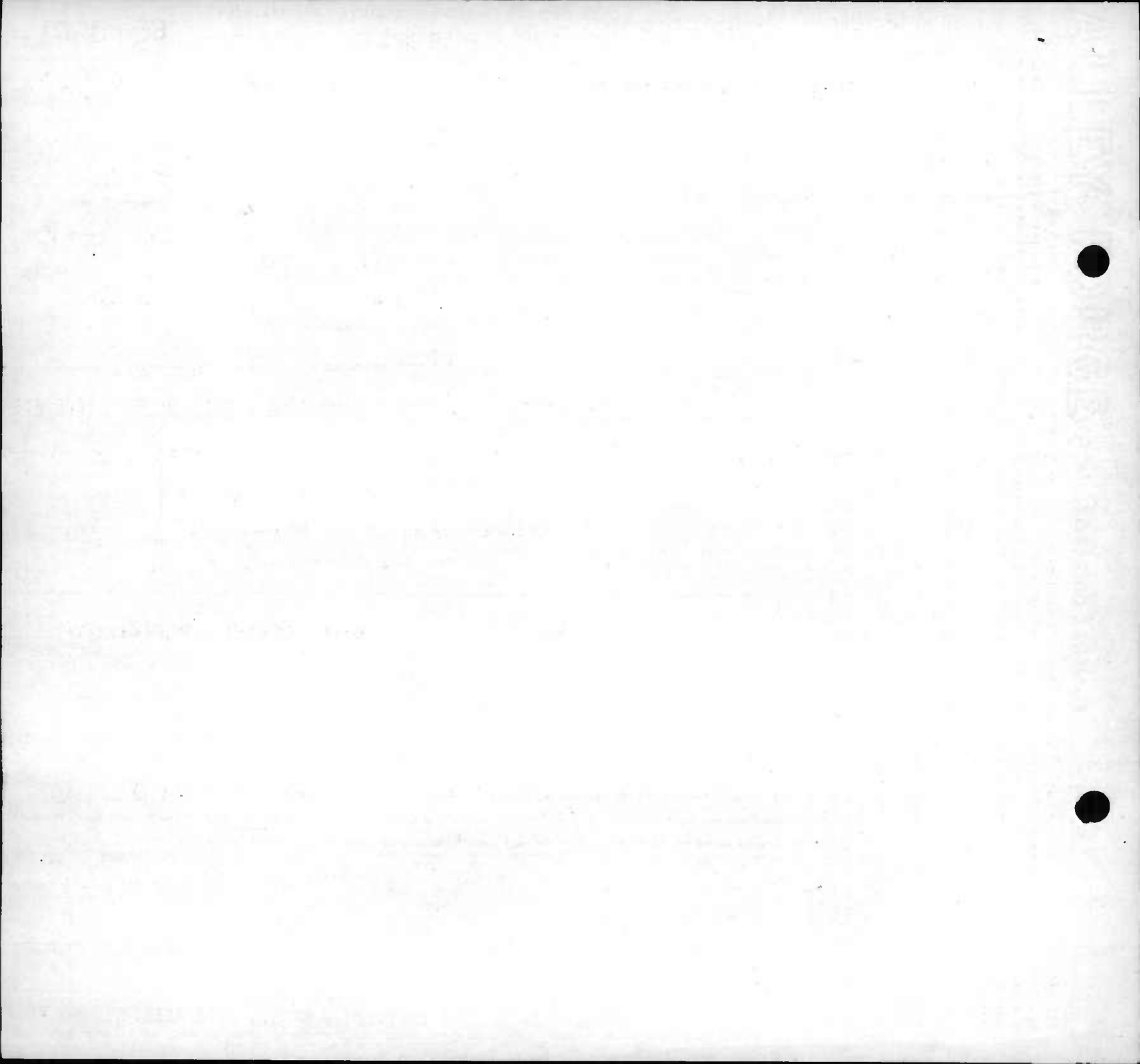
Glen Burnie, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

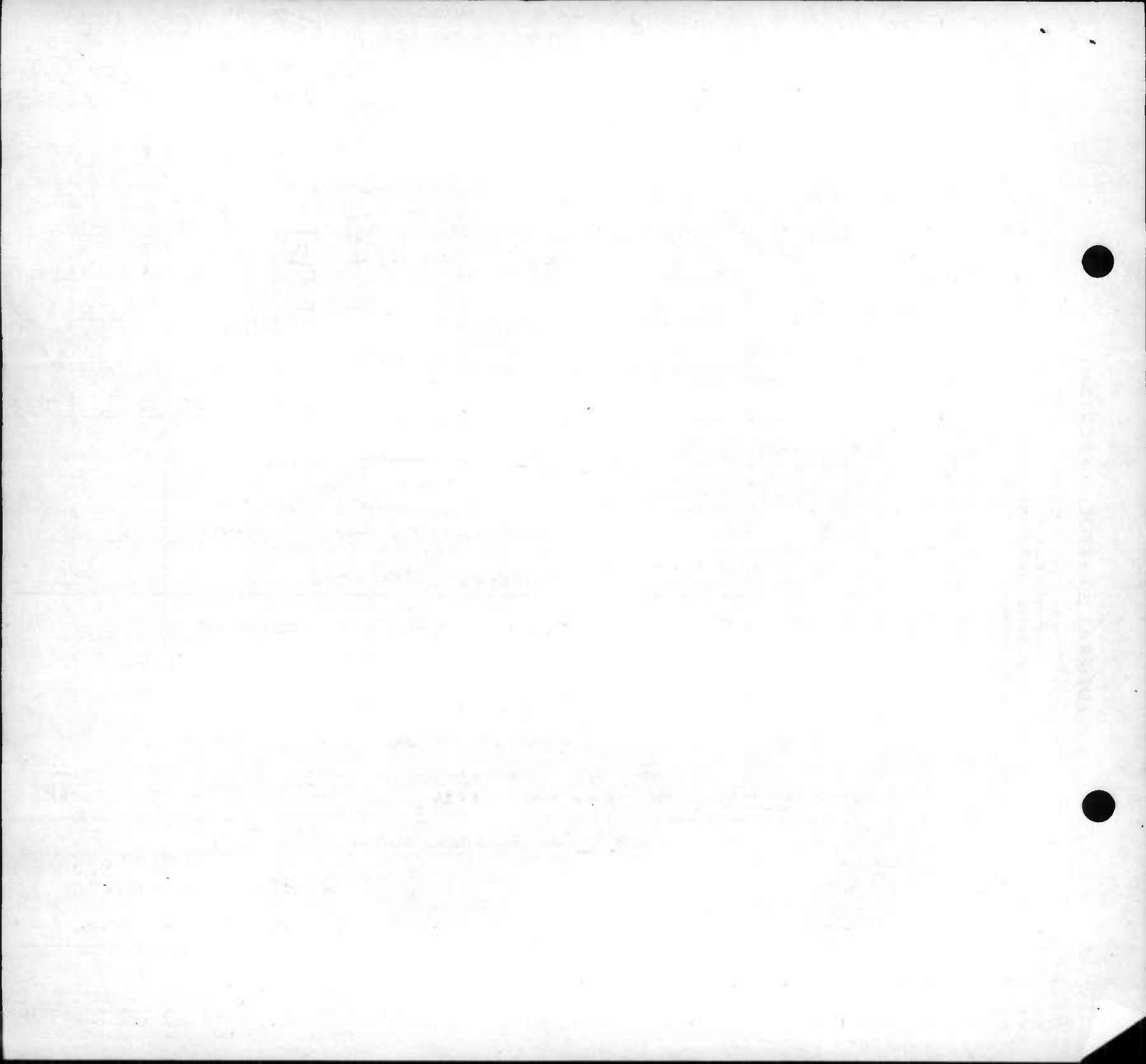
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-1201</u>
<div style="display: flex; justify-content: space-between;"> S-615 68-1201 CERTIFICATE OF DEATH </div>				
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>BENJAMIN SCHREIBMAN</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>1/28/68</u> <u>6:20</u> <u>A</u> M.		
FULL NAME OF HOSPITAL OR INSTITUTION <u>12 SINAI HOSPITAL OF BALTIMORE</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAILOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>SHOP (HOLLAND CLEANERS)</u>		
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-05-2123A</u>		
17. INFORMANT <u>MRS. MINNIE SCHREIBMAN</u>		ADDRESS <u>7012 SURREY DRIVE #15</u>		
18. CAUSE OF DEATH <u>492 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>527.1 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>CO₂ NARCOSIS</u> <u>CHRONIC OBSTRUCTIVE EMPHYSEMA WITH COR PULMONALE</u> <u>CHRONIC MENTAL DEPRESSION</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>6</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>12/18/67</u> to <u>1/28/68</u> , that (I) (we) last saw the deceased alive on <u>1/28/68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Thomas R. Smith</u>				23B. DATE SIGNED <u>1/28/68</u>
23C. PHYSICIAN'S NAME (Type) <u>THOMAS R. SMITH</u>				23D. ADDRESS <u>SINAI HOSP.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-29-68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>JEWISH FORBAND</u>
24D. LOCATION (City, town, or county) (State) <u>ROSEDALE</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 31 1968</u>		
25B. NAME OF REGISTRAR <u>Paul E. Taylor</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

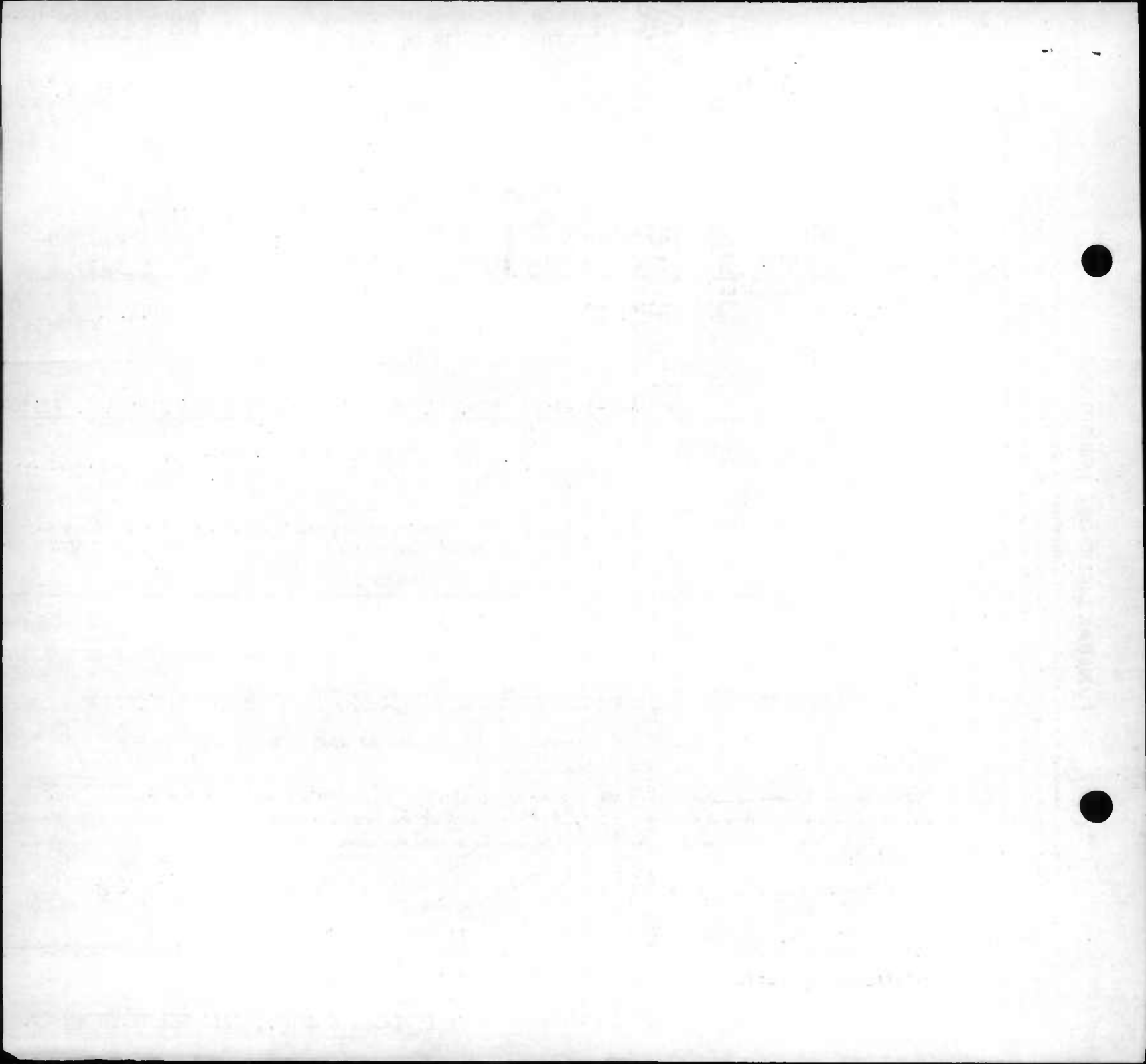
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1202	
G-431 68-1202				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) GERTRUDE GOLDBERG		2. DATE AND HOUR OF DEATH 1/27/68 10⁰⁷/P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 SINAI HOSPITAL OF BALTIMORE				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 6706 BENHURST RD 27-20	
5. SEX Female	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/3/1906	9. AGE (In years last birthday) 61	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME MORRIS ABRAMSON			14. MOTHER'S MAIDEN NAME CLARA ENGELMAN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-16-6972		17. INFORMANT ADDRESS MRS. MIRIAM ARMON, 6204 BENHURST ROAD, #21209	
18. 250.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIO-PULMONARY ARREST ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MYOCARDIAL INFARCTION AND (B) ARTERIO-SCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF: (C) DIABETES MELLITUS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19. 260X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). CEREBRAL VASCULAR ACCIDENT					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/26 1968 to 1/27 1968 , that (I) (we) last saw the deceased alive on 1/27 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas P. Smith				23B. DATE SIGNED 1/28/68	
23C. PHYSICIAN'S NAME (Type) Thomas P. Smith				23D. ADDRESS SINAI HOSPITAL OF BALTIMORE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-29-68		24C. NAME OF CEMETERY or CREMATORY BNAI ISRAEL	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JAN 31 1968			
25B. NAME OF REGISTRAR Robert E. Tarkenton		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						REG. NO. <u>68-1203</u>
<div style="display: flex; justify-content: space-between;"> <u>C-150</u> 68-1203 CERTIFICATE OF DEATH </div>						
1. NAME OF DECEASED (Type or Print) <u>HARRY LEVINE</u>			2. DATE AND HOUR OF DEATH <u>JANUARY 29, 1968</u> <u>10:30 P.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>42 SINAI HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>28-41</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>5500 CHANDLER AVENUE #21207</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 26, 1911</u>	9. AGE (In years last birthday) <u>56</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BILLIARDS</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BILLIARDS</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>PROPRIETOR</u>		11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>LOUIS LEVINE</u>			
14. MOTHER'S MAIDEN NAME <u>MOLLIE ?</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>348-12-1690</u>			17. INFORMANT <u>MRS. FLORENCE LEVINE, 5500 CHANDLER AVE. #21207</u>			
18. <u>412.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Acute Myocardial Infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Coronary Artery Disease 10-15 yrs.</u>						
19. <u>420.1</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).						
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>Nov 1965</u> to <u>1/22 1968</u> , that (I) (we) last saw the deceased alive on <u>1/22 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE <u>Leonard Kotz MD</u>				23B. DATE SIGNED <u>1/30/68</u>		
23C. PHYSICIAN'S NAME (Type) <u>DR. LEONARD KOTZ</u>				23D. ADDRESS <u>11 SLADE AVENUE</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>REMOVAL-BURIAL</u>		24B. DATE <u>1-31-68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>ORDER OF KNIGHTS OF JOSEPH</u>		
24D. LOCATION (City, town, or county) (State) <u>CHICAGO, ILLINOIS</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 31 1968</u>				
25B. NAME OF REGISTRAR <u>Robert E. Leary</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN RD.</u>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-1204</u>
68-1204				CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>ANNA Lee KIRBY</u>		2. DATE AND HOUR OF DEATH <u>January 27, 1968 2:15 P.M.</u>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>27-03</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>5220 TRAMORE ROAD</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>07-08-90</u>	9. AGE (In years last birthday) <u>77</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Benedict MARYLAND</u>
13. FATHER'S NAME <u>JOHN R. EDWARDS</u>		14. MOTHER'S MAIDEN NAME <u>LUCINDA GRAVES</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-36-7320B</u>		17. INFORMANT <u>Rev. Clarence E. Kirby, husband, above</u>
18. <u>412.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>ACUTE CONGESTIVE FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>W.K.W.</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>January 23, 1968</u> to <u>January 27, 1968</u> , that (I) (we) last saw the deceased alive on <u>January 27, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Clarence E. Kirby</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>January 27, 1968</u>
23C. PHYSICIAN'S NAME (Type) <u>DR. MIGUEL SANCHEZ-BALSICOS</u>		23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u> <u>THE UNION MEMORIAL HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>1/30/68</u>	24C. NAME OF CEMETERY or CREMATORY <u>Parkwood Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 31 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Schimunek Funeral Home, Inc.</u> <u>3331 Brehms Lane</u>

2550 TRAMING ROAD

07-08-20 JJ

MARYLAND

LUCINDA GRAYES

JOHN R. BARBER

F W X

ACUTE RESPIRATORY FAILURE

DETERIORATION - CARDIAC & PULMONARY

and

January 25, 08
January 23, 08
January 21, 08

W. J. Barber

X

W. J. Barber

W. J. Barber

1
R-140

68-1205 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-1205

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) EDWARD JOSEPH ROUBAL Sr.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> January 29, 1968 6:30 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL (DOA) (If not in hospital or institution, give street address or location)		3. DATE PRONOUNCED DEAD Month Day Year Hour January 29, 1968 6:30 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland 21222 B. COUNTY 53-00	
9. DATE OF BIRTH 7/27/1912		10. AGE (In years last birthday) 55 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph Roubal		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Silversmith	
148. KIND OF BUSINESS OR INDUSTRY Samuel Kirk		15. MOTHER'S MAIDEN NAME Sophie Kriss	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 215-07-2301	
18. INFORMANT Mrs. Marlene Leonard, dght. above		ADDRESS	
19. 412.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-30-68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/2/68	
24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 31 1968		25B. NAME OF REGISTRAR Robert E. Tarkenton	
25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 3331 Brehms Lane	

WALTER BOWEN

202 May 1917

W. B. Bowen

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1206

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-1206

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

SALGADO, ELIZABETH

2. DATE AND HOUR OF DEATH

28th JAN. '68 11:20 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

36 FRANKLIN SQUARE HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY

M.D. EASTPOINT

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☐

NO ☐

E. STREET AND NUMBER

431 52ND ST.

5. SEX

F

6. RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

4/14/09

9. AGE (In years last birthday)

60

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

GERMANY

12. CITIZEN OF WHAT COUNTRY?

U. S. A

13. FATHER'S NAME

Theodor Krappmann

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

214-24-7330

17. INFORMANT

LOUIS SALGADO

ADDRESS

2124 431 52ND St. Balt. Md.

18. 486X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Aspiration pneumonia

(B)

DUE TO, OR AS A CONSEQUENCE OF:

and CVA

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

491X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3th JAN 19 68 to 28th JAN 19 68, that (I) (we) last saw the deceased alive on 11 20 PM 28th JAN 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Cheryl Ann Kwon M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

28th JAN. '68

23C. PHYSICIAN'S NAME (Type)

Dr. DE LEON

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

I-31-68

24C. NAME OF CEMETERY or CREMATORY

Oak Lawn Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JAN 31 1968

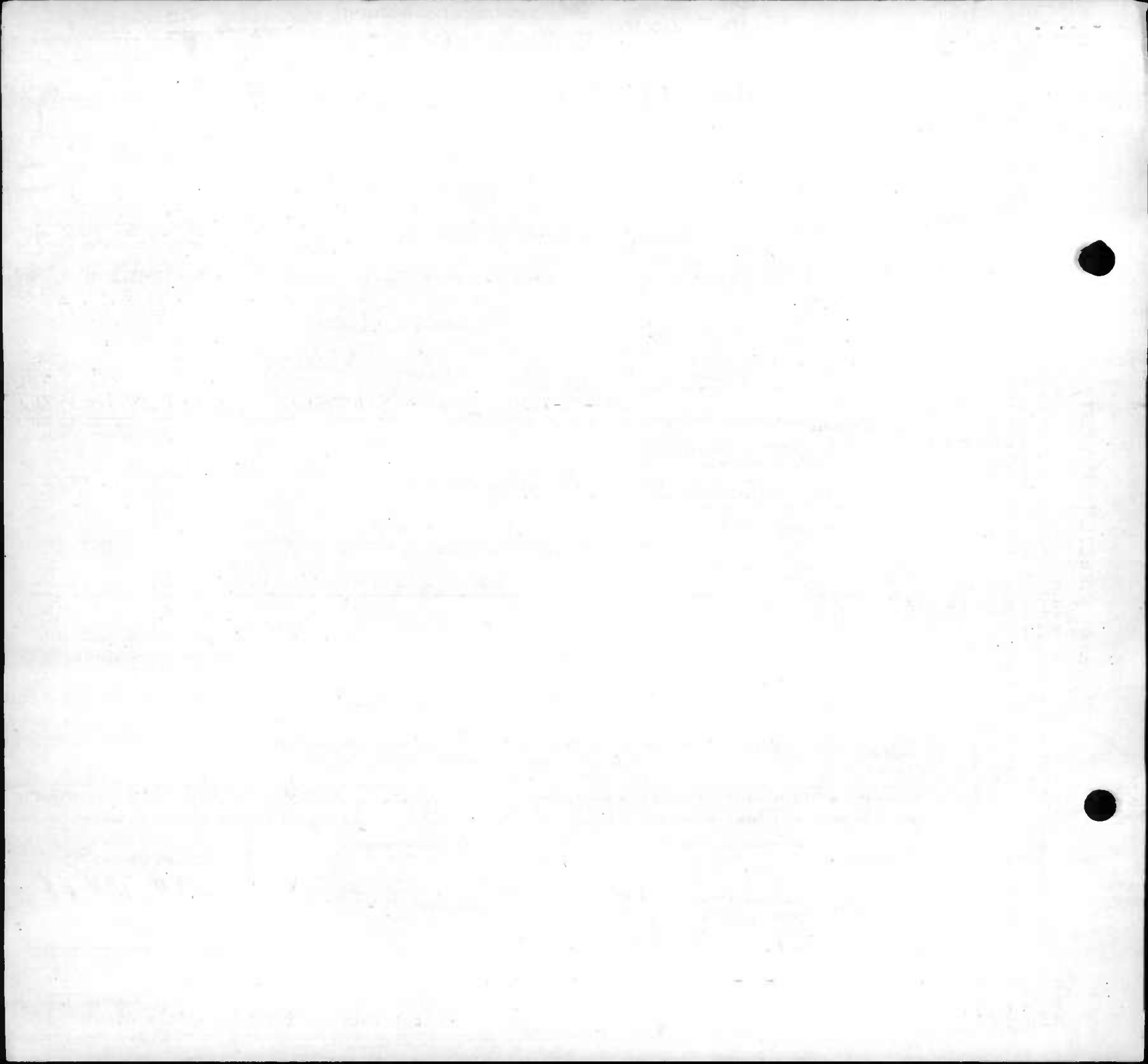
25B. NAME OF REGISTRAR

Robert E. Falsch

25C. FUNERAL DIRECTOR

Walter Dabrowski 1005 Dundalk Avenue

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 68-1207	
68-1207 CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Leiter, Benjamin</u>				1-28-1968 11:20 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital of Baltimore</u>		A. STATE Maryland		B. COUNTY Baltimore	
		C. CITY OR TOWN Baltimore		(If outside city limits, write RURAL and give township)	
		D. STREET ADDRESS <u>W 2708 Bartol Ave. #9</u>		(If rural, give location)	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>never married</u>	8. DATE OF BIRTH <u>7-7-1909</u>	9. AGE (In years last birthday) <u>58-56</u>	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>self employed</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State of foreign country) <u>Phila. Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Max Leiter</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Joseph Leiter 2708 Bartol Ave. 21209</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>157.9 + 1250.9</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <u>malignant tumor of pancreatic ca</u> DUE TO			
		(B) <u>Diabetes mellitus</u> DUE TO			
		(C) <u>duodenal ulcer</u> DUE TO			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>157X II</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>January 10 1968</u> to <u>January 28 1968</u> that (I) (we) last saw the deceased alive on <u>January 28 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Myung Sun Yoon</u> M.D.				23B. DATE SIGNED <u>1-28-68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Myung Sun Yoon</u> M.D.				23D. ADDRESS <u>Sinai Hospital Belvedere & Greenspring, Ave.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Jan. 30th</u>		24C. NAME OF CEMETERY or CREMATORY <u>Har Zion Tifereth Israel</u>	
24D. LOCATION <u>Rosedale</u>		24E. (City, town, or county) <u>Md.</u>		24F. (State)	
25A. DATE RECEIVED BY HEALTH DEPT. <u>JAN 31 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Sylvan S. Lewis & Son P.O. Box 65 Garrison, Md.</u>	
				25D. ADDRESS <u>Memorial Chapel.</u>	

80 N. 1/2 Sec. 10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1208

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

REG. NO.

68-1208

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Edward Zimmerman

2. DATE AND HOUR OF DEATH

1/29/68

1 35 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Maryland Gen. Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md.

14-01

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

Bolton Hill Nursing home

5. SEX

M

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

3/19/1900

9. AGE (In years last birthday)

67

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Carpenter

10B. KIND OF BUSINESS OR INDUSTRY

Shipping

11. BIRTHPLACE (State or foreign country)

Balt. Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William Zimmerman

14. MOTHER'S MAIDEN NAME

Unknown?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

215-10-0525

17. INFORMANT

ADDRESS

Muriel M. Rauch 1819 Summit Ave

18. 485X I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

Respiratory arrest

(B) DUE TO, OR AS A CONSEQUENCE OF:

Broncho pneumonia

(C) DUE TO, OR AS A CONSEQUENCE OF:

Chronic Obstr. Airway Dis.

481X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

NO

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/25/68 19 to 1/29/68 19

that (I) (we) last saw the deceased alive on 1/29/68 19

and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Ralph D. Raymond MD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1/29/68

23C. PHYSICIAN'S NAME (Type)

Ralph REYMOND

23D. ADDRESS

Maryland Gen. Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1/31/68

24C. NAME OF CEMETERY or CREMATORY

Glen Haven Cemetery

24D. LOCATION

Baltimore, Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 31 1968

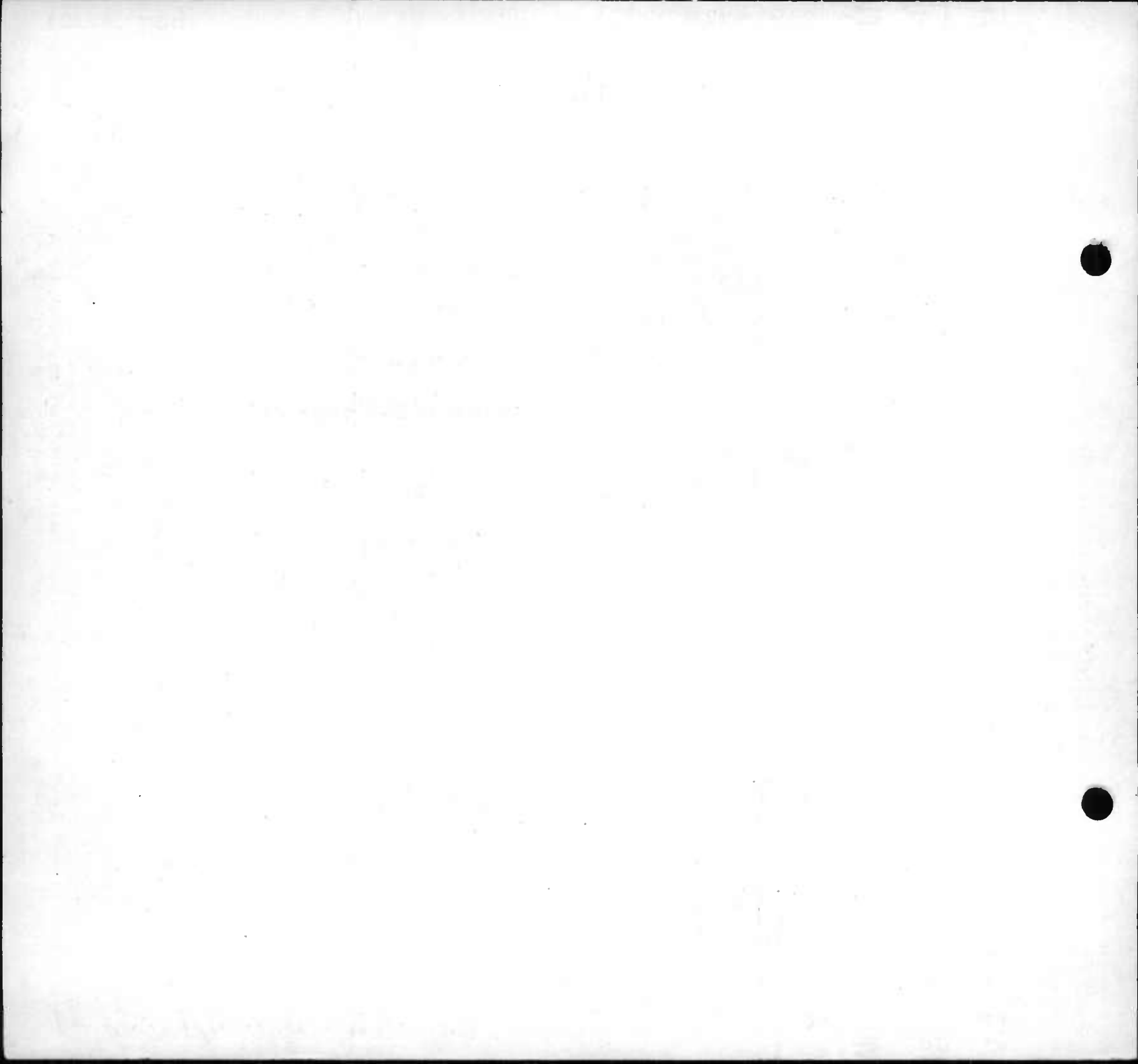
25B. NAME OF REGISTRAR

Robert E. Feltner

25C. FUNERAL DIRECTOR

Ambrose Inc. 1328 Sulphur Sp. Rd.

ADDRESS

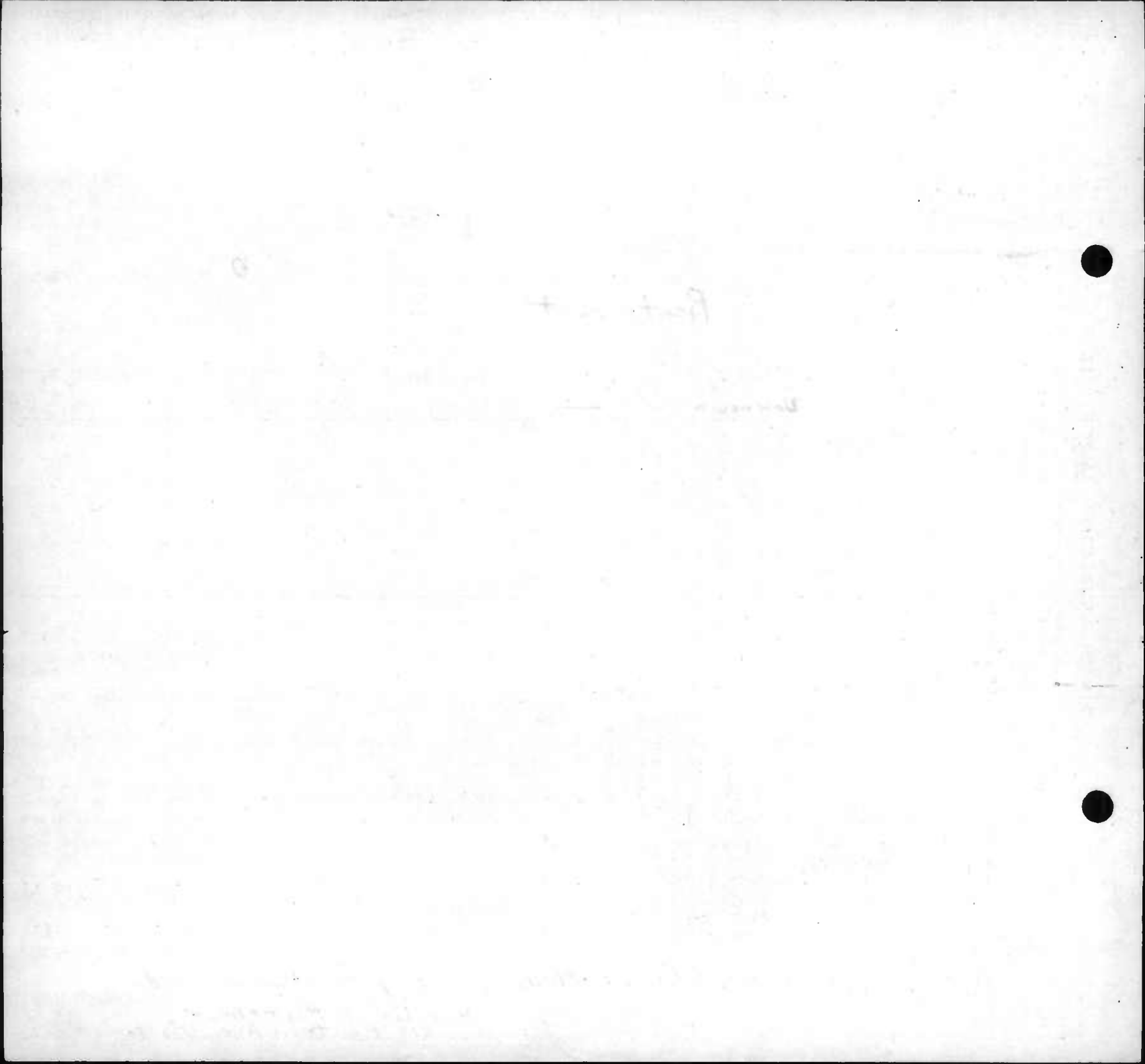


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

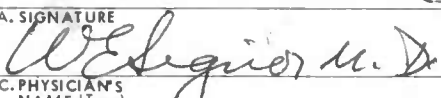
MEDICAL CERTIFICATION

BIRTH NO. 68-1209		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1209	
1. NAME OF DECEASED (Type or Print) DEMETRIDES, ATHANASIOS		2. DATE AND HOUR OF DEATH JAN. 25, 1968 11:20 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) FRANKLIN SQUARE HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 26-36 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 6907 BOSTON AVE.			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-23-89	9. AGE (In years last birthday) 70	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED.		10B. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) TURKEY	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN DEMETRIDES		14. MOTHER'S MAIDEN NAME ANGELIKI	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES Unknown		16. SOCIAL SECURITY NO. —		17. INFORMANT DESPINA DEMITRIDES ADDRESS 6707 BOSTON AVE.	
18. 436.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 331x II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE CVA DUE TO, OR AS A CONSEQUENCE OF: (B) Hypertension DUE TO, OR AS A CONSEQUENCE OF: (C) years		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3:15 PM, JAN. 22 1968 to 11:20 PM, JAN. 25 1968 , that (I) (we) last saw the deceased alive on JAN. 25 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Hyung K. Lee, M.D.				23B. DATE SIGNED JAN. 25, 1968	
23C. PHYSICIAN'S NAME (Type) HYUNG KON LEE, M.D.		23D. ADDRESS 100 N. CALHOUN ST. BALTIMORE, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-29-68		24C. NAME OF CEMETERY or CREMATORY Greek Orthodox Cemetery Baltimore, Md.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. JAN 31 1968		25B. NAME OF REGISTRAR R. E. E. Jackson	
25C. FUNERAL DIRECTOR Nicholas T. Matthews		ADDRESS 3021 Eastern Ave., Baltimore, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 68-1210	
<div style="display: flex; justify-content: space-between;"> 68-1210 CERTIFICATE OF DEATH </div>					
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		MARY ANN LAWYER		JANUARY 29, 1968 9:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTO. 21229 MD.		A. STATE MARYLAND B. COUNTY PASADENA 21122 C. CITY OR TOWN (If outside city limits, write RURAL and give township) PASADENA 21122 D. STREET ADDRESS (If rural, give location) RT 5, BOX 246 MAGOTHY BEACH			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
FEMALE	WHITE	WIDOWED	12/28/80	87	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE				MARYLAND	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
JOHN R. DE VOS			BARBARA ZANER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		212031698		ST. AGNES HOSPITAL, WILKENS & CATON AVE	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Upper G.I. Hemorrhage (A) DUE TO				Days.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Unknown etiology (B) DUE TO					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASCVD & Congestive Heart Failure (C) DUE TO				Year	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2 None				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
No					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>JANUARY 19</u> 19 <u>68</u> to <u>JANUARY 29</u> 19 <u>68</u> , that (I) <u>we</u> last saw the deceased alive on <u>JANUARY 29</u> 19 <u>68</u> and that in <u>my</u> <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> <u>did</u> <u>did not</u> view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
 WILLIAM E. SIGNOR				1/30/68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
WILLIAM E. SIGNOR		ST. AGNES HOSP WILKENS & CATON BALTO MD 21229			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		2-2-1968		Louden Park Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 31 1968		Robert E. Farkner		George J. Gonce-4001 Ritchie Hwy., Baltimore	

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1211

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-1211

BIRTH NO.		1. NAME OF DECEASED (Type or Print) EUGENE G. WAGNER		2. DATE AND HOUR OF DEATH 1-26-68 5²⁰ A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Lansdowne D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3018 Bero Rd		5. SEX Male 6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 9/12/28		9. AGE (In years last birthday) 39		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Henry Wagner	
14. MOTHER'S MAIDEN NAME Mary Grace		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-22-8113	
17. INFORMANT Catherine CONRAD		ADDRESS 3018 Bero Rd		18. CAUSE OF DEATH CHRONIC BRONCHITIS & COR PULMONALE & POLYCYTHEMIA & OBESITY	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unk		19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA		20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 30211 II	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). TRACHEOESOPHAGEAL FISTULA		21. DATE OF OPERATION 30211		22. CONDITION FOR WHICH OPERATION WAS PERFORMED	
23. AUTOPSY? (Yes or No) NO		24. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		25. MEDICAL CERTIFICATION	
26. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
29. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		30. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		31. HOW DID INJURY OCCUR?	
32. I certify that (I) (this hospital) attended the deceased from 1-9-68 19 to 1-26-68 19, that (I) (we) lost saw the deceased alive on 1-26-68 19 and that in (my) (our) opinion death occurred on the date and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
33. SIGNATURE B. A. Portway MO		34. DATE SIGNED 1-26-68		35. PHYSICIAN'S NAME (Type) MO	
36. ADDRESS UNIVERSITY HOSPITAL		37. BUREL CREMATION, REMOVAL (Specify) Burial		38. DATE 1/30/68	
39. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		40. LOCATION (City, town, or county) Dorsey, Maryland		41. (State)	
42. DATE REC'D BY HEALTH DEPT. JAN 31 1968		43. NAME OF REGISTRAR Robert E. Fairbank		44. FUNERAL DIRECTOR Amberline Inc 1324 S. Sp. Rd.	

UNIVERSITY OF MICHIGAN

CHURCH OF THE HOLY SPIRIT
1212 N. ZEEB RD.
ANN ARBOR, MI 48106

BRANCH OF THE CHURCH

TRACED TO THE CHURCH

NO

1-2-88
1-2-88

NO

UNIVERSITY OF MICHIGAN

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HOWARD EISENHOOD		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour January 24, 1968 6:00 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour January 24, 1968 6:00 P.M.	
6. SEX Male		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 18-03	
7. RACE White		C. CITY OR TOWN Baltimore	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years last birthday) XX 70	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Howard Eisenhood		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carrier	
15. MOTHER'S MAIDEN NAME Amanda -		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Geo. R. Gordon 837 Hollins St.	
19. CAUSE OF DEATH E 814.7 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 1-24-68		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED Multiple injuries	
21. AUTOPSY? (Yes or No) No		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Eastern and Broadway	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 1-24-68 2:25 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> Pedestrian struck by tractor-trailer	
22F. HOW DID INJURY OCCUR? Pedestrian struck by tractor-trailer		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-25-68	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/31/68	
24C. NAME OF CEMETERY or CREMATORY Glen Haven		24D. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 31 1968		25B. NAME OF REGISTRAR Robert E. Farkner	
25C. FUNERAL DIRECTOR JOHN F. DENNY, INC.		ADDRESS 715 Light St.	

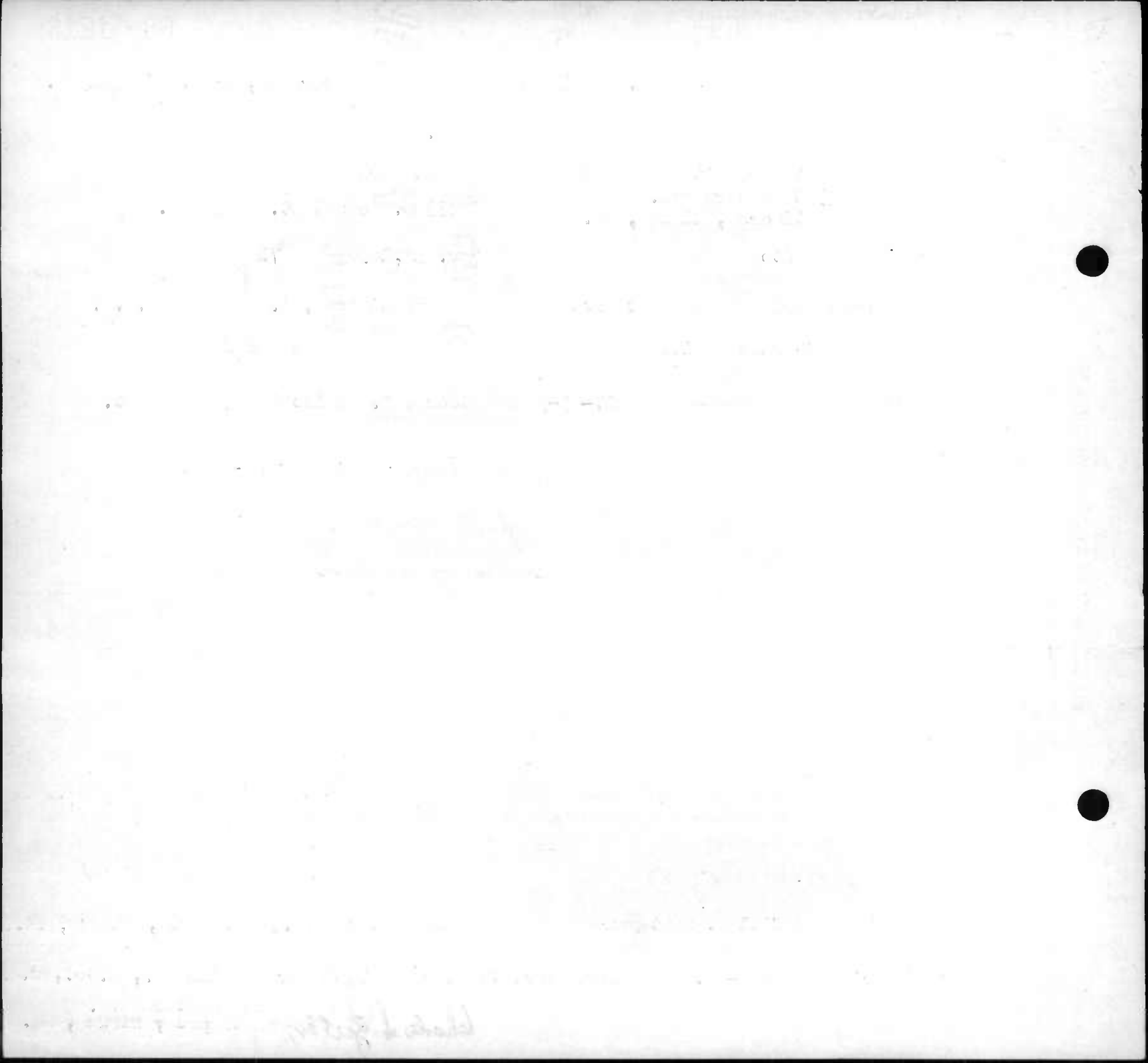
1. Information about the company's
products and services

Charles H. Lawrence, Jr.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1213		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 1213	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MABEL T. PINIECKI		January 26, 1968. 4:15 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Ave. Baltimore, 21224, Md.			A. STATE Md.		
			B. COUNTY		
C. CITY OR TOWN Baltimore			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 433 S. Bonsal St. # 21224.					
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1896	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles White		14. MOTHER'S MAIDEN NAME Mae Griffin	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-03-9688		17. INFORMANT George P. Piniecki	
ADDRESS Same.					
18. 436.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
CAUSE OF DEATH A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral vascular accident Hypertension arteriosclerosis					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION 331 X II					
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					
20A. AUTOPSY? (Yes or No)					
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on Aug 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rafael A. Santayana				23B. DATE SIGNED 1-29-68	
23C. PHYSICIAN'S NAME (Type) Rafael A. Santayana				23D. ADDRESS 6010 Eastern Ave., Baltimore, 21224, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-30-68.		24C. NAME OF CEMETERY or CREMATORY Sacred Heart Cemetery	
24D. LOCATION (City, town, or county) (State) 7401 German Hill Rd., Ba. Co., Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR Charles J. Giller	
				ADDRESS 6224 Eastern Ave. Baltimore, 21224, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1214

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-1214

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

EDITH KEECH

2. DATE AND HOUR OF DEATH

27 JAN 1968 12 05 PM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

35 Church Home & Hospital
BALTIMORE Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

CHURCH HOME

6-05

5. SEX

F

6. RACE

CAUC

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

12-25-1876

9. AGE (In years last birthday)

91

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Henry Keach

14. MOTHER'S MAIDEN NAME

ELISABH MARTIN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

-

17. INFORMANT

Miss Mary Plummer

ADDRESS

101 W MONUMENT ST
BALTO MD.

18.

412.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CONGESTIVE HEART FAILURE

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) ASCVD

(C) Pneumonia, Viral

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Rodolfo M. Gini

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1-27-68

23C. PHYSICIAN'S NAME (Type)

Rodolfo

23D. ADDRESS

CHH

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

Jan. 30, 1968

24C. NAME OF CEMETERY OR CREMATORY

Prospect Hill Cemetery

24D. LOCATION (City, town, or county)

Towson, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 31 1968

25B. NAME OF REGISTRAR

Robert E. Johnson

25C. FUNERAL DIRECTOR

John Burns Sons, Towson, Md.

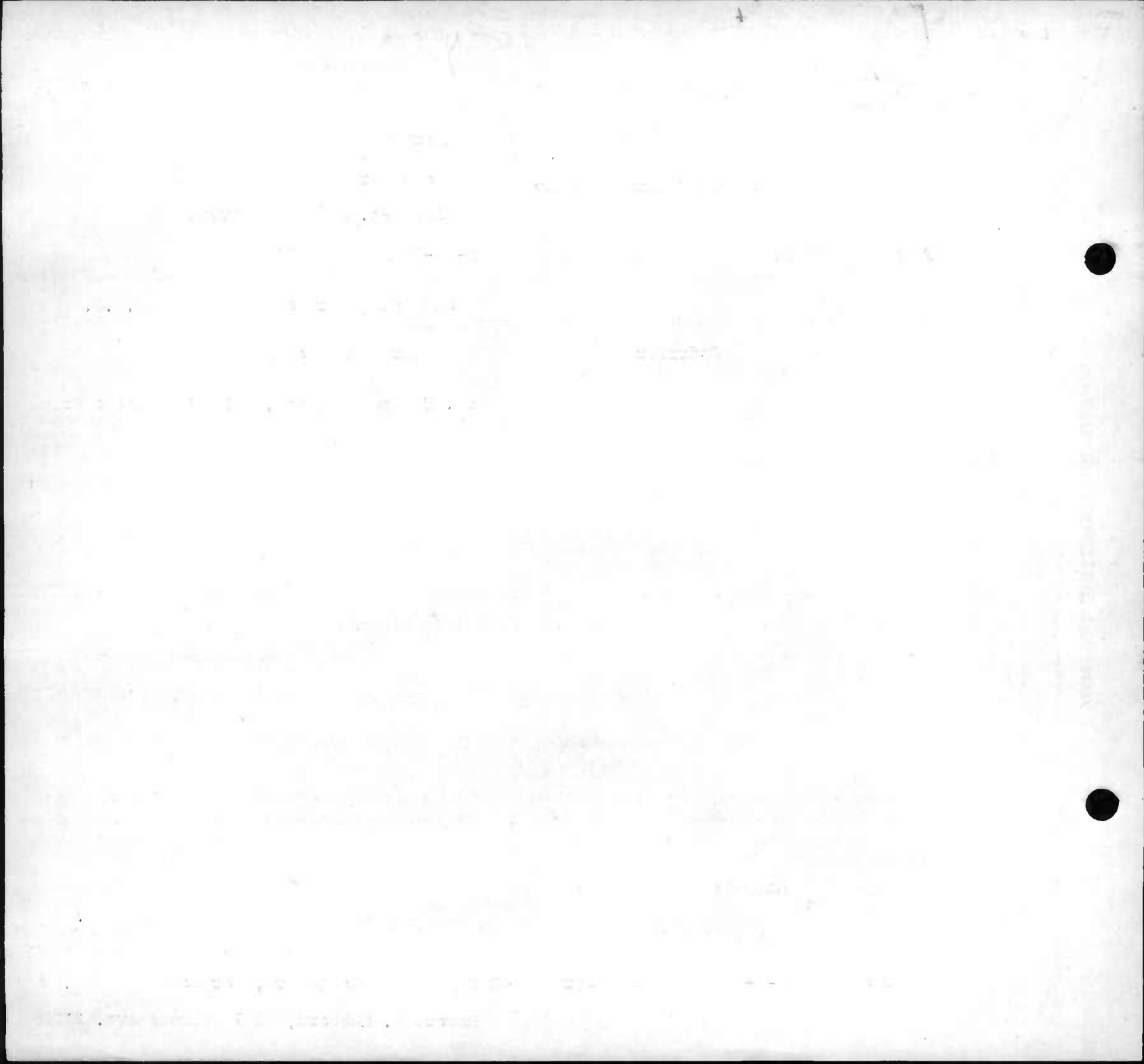
ADDRESS

Rebelle
Le 10/10/10

CH 4

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

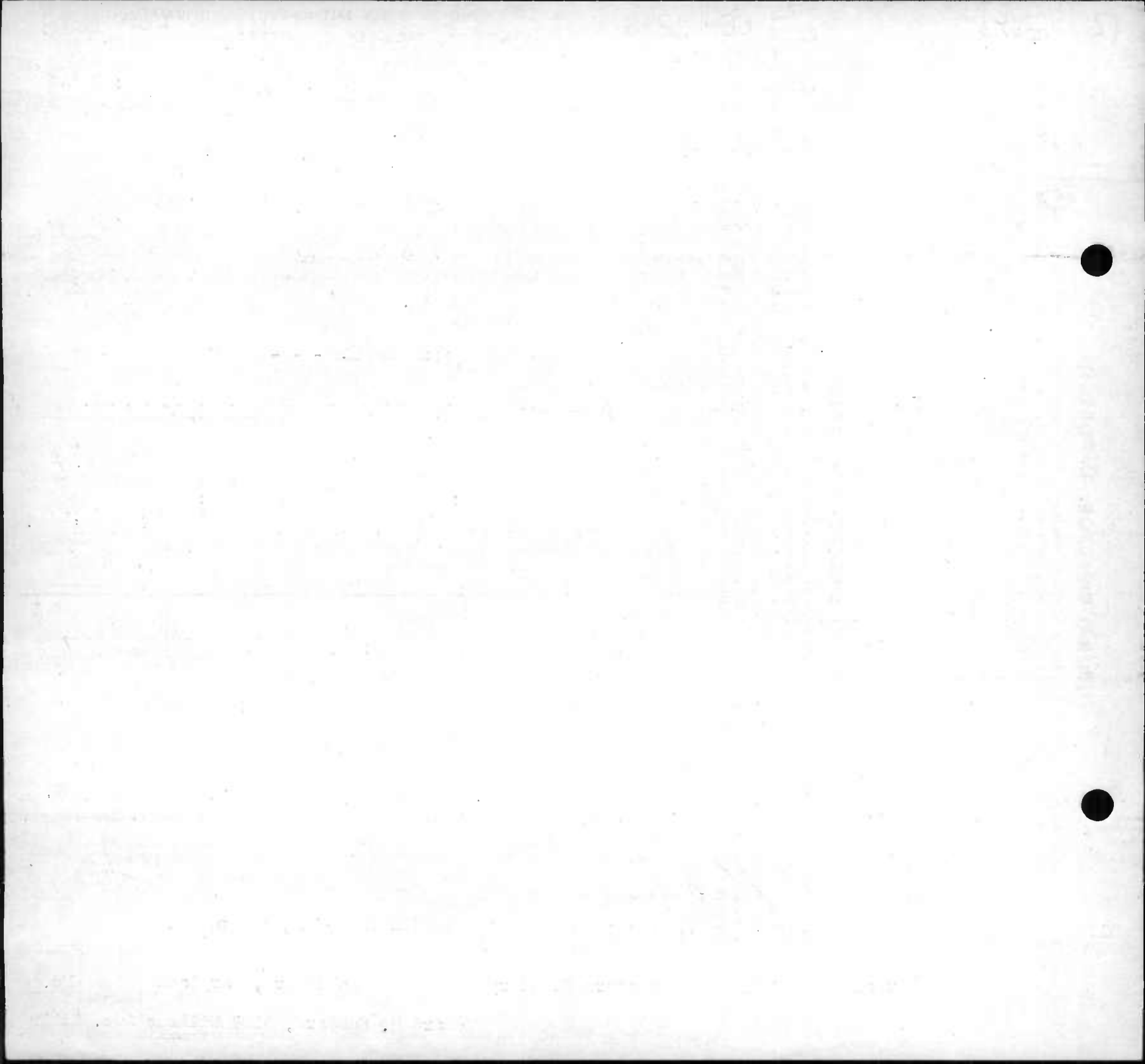
68-1215 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 68-1215	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) DAISY Plunkert		2. DATE AND HOUR OF DEATH 1-29-68 4:30 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 South Baltimore General Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 20-05 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2680 St. Benedict Street		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-10-1895	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Spurrier			14. MOTHER'S MAIDEN NAME Henrietta Chaney		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Thomas Sullivan, 1038 Glen Villa Drive	
18. I 174X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Breast Cancer CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. II 170X OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Metastasis to liver					
19A. DATE OF OPERATION 1-27-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED LIVER Biopsy.		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-19-1968 to 1-29-1968 , that (I) (we) lost saw the deceased alive on 1-29-1968 and that in (my) (our) opinion death occurred on the date and hour of 1-29-1968 from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jose V. Iglesias				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Jose V. Iglesias				23D. ADDRESS South Baltimore General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-1-1968		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR Howard H. Hubbard		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. X
68- 1216		68- 1216		
BIRTH NO.		2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) James Oscar Reher		Jan. 28, 1968		8:52 A M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 53-00		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 3100 Wyman Pk. Drive		C. CITY OR TOWN Baltimore Co		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 4322 Barrington Road 21229		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/7/03	9. AGE (In years lost birthday) 64
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Engineer		10B. KIND OF BUSINESS OR INDUSTRY Seafarer		11. BIRTHPLACE (State or foreign country) Calif.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Reher		
14. MOTHER'S MAIDEN NAME xxk Nollie - - -		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes USN 1920-1921		
16. SOCIAL SECURITY NO. 251-18-8053		17. INFORMANT Records- US PHS Hospital, Balto, Md.		
18. 157.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Obstruction of hepatic duct ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Carcinoma of the pancreas		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks. + Unknown		
19. 157X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from Dec. 18 19 67 to Jan. 28 19 68 , that (I) (we) last saw the deceased alive on Jan. 28 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Norman H. Peckham</i>		23B. DATE SIGNED 1/29/68		23C. PHYSICIAN'S NAME (Type) Norman H. Peckham, Surgeon (R)
23D. ADDRESS US PHS Hospital, Balto, Md.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 2/1/68		24C. NAME OF CEMETERY or CREMATORY Western Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland Md.
25A. DATE REC'D BY HEALTH DEPT. JAN 31 1968		25B. NAME OF REGISTRAR <i>Robert E. Folsom</i>		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229



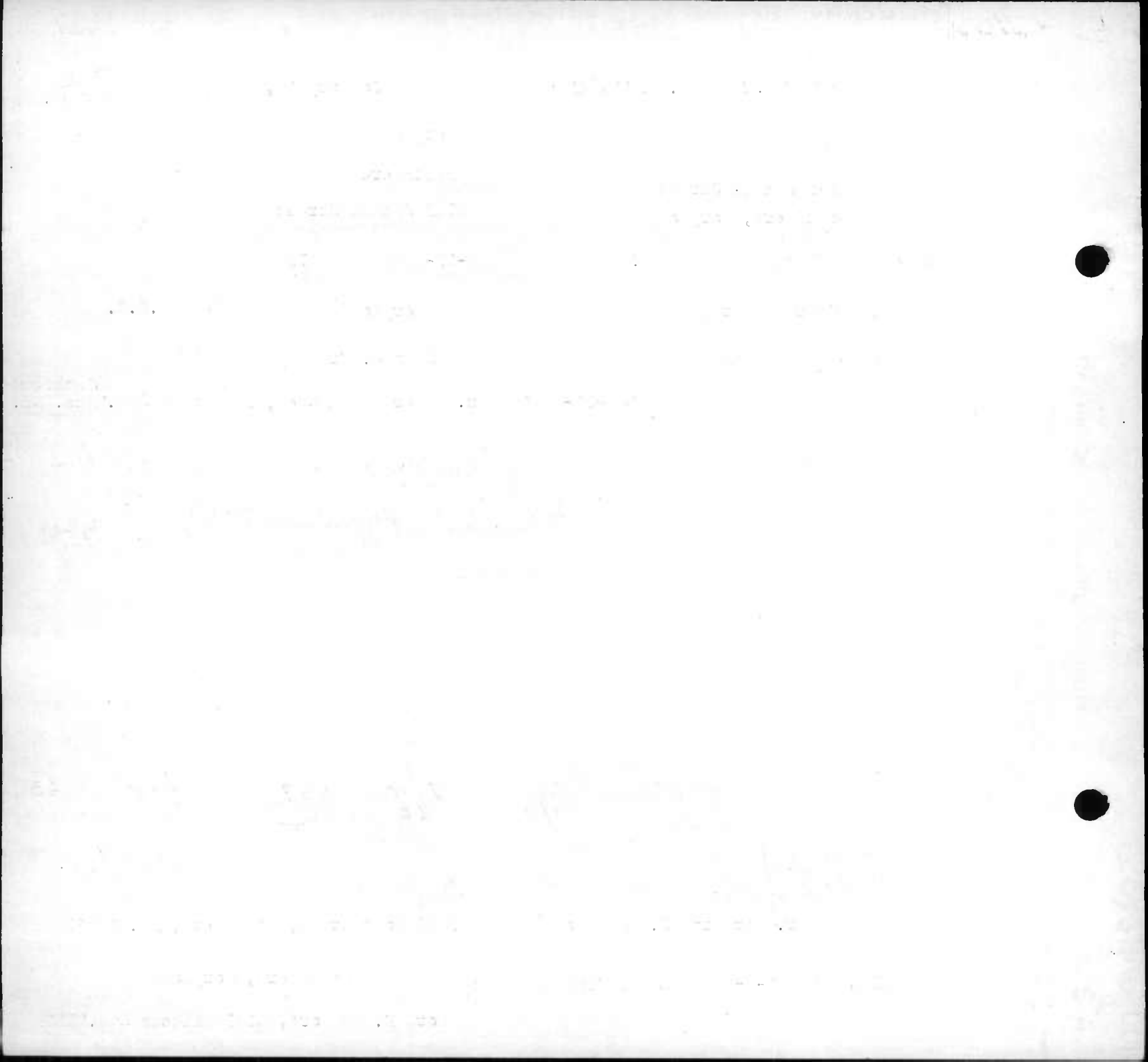
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-1217 CERTIFICATE OF DEATH

REG. NO. 68-1217

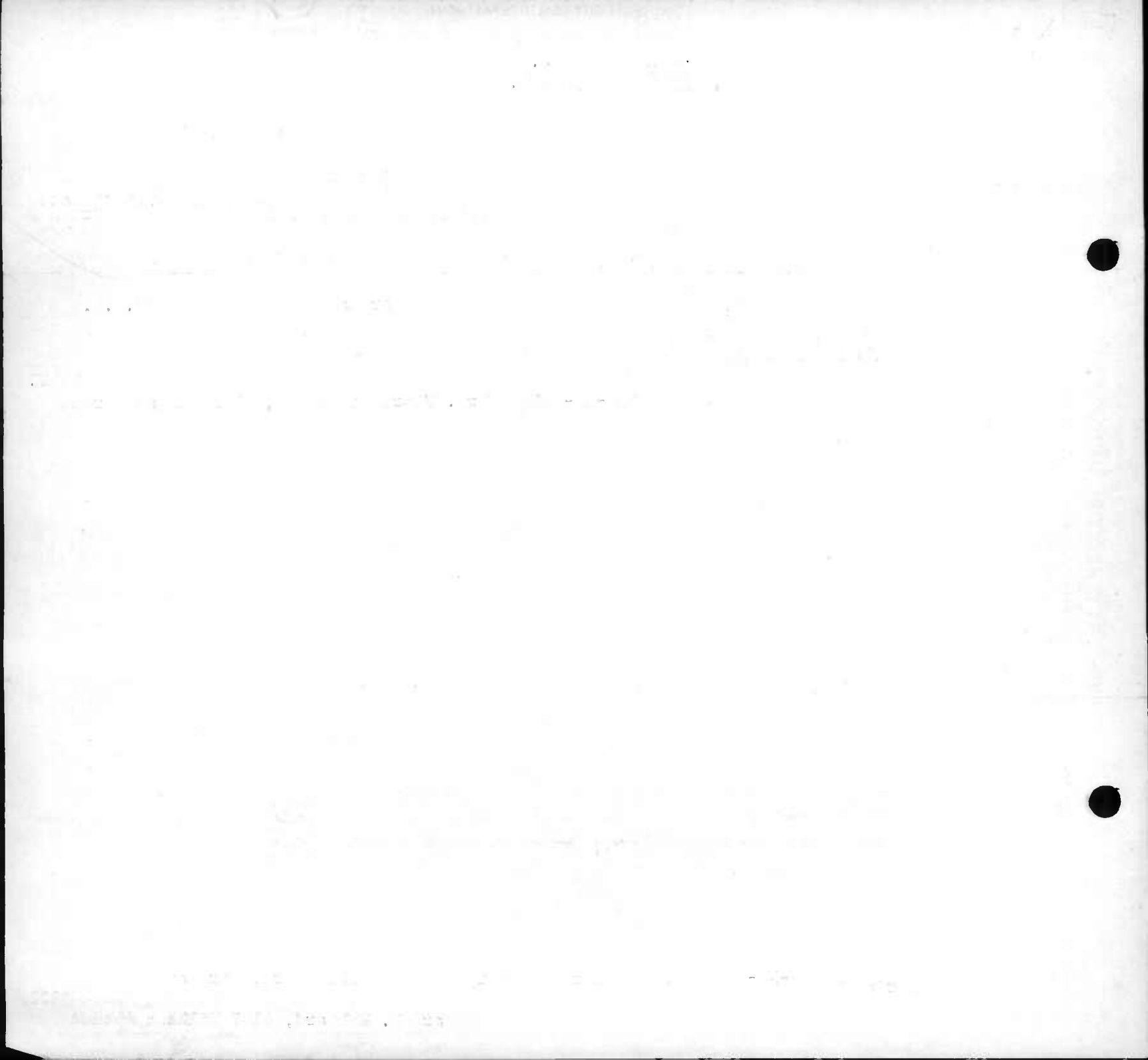
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MARGARET B. EGGLESTON		2. DATE AND HOUR OF DEATH January 29, 1968 7 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 1715 Spence Street Baltimore, Maryland			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Female			6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Store Owner			10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 4-23-1888
11. BIRTHPLACE (State or foreign country) Maryland			9. AGE (In years last birthday) 79		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME John Hein		
14. MOTHER'S MAIDEN NAME Anna C. Grothey			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 219-32-0042			17. INFORMANT Mr. Howard Eggleston, 319 Hance Ave. Hgts. Md.		
18. 412.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Anteroselectic Hypertensive CVD, ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. stroke			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral hemorrhage (B) DUE TO, OR AS A CONSEQUENCE OF: ? (C) stroke		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/10 19 67 to 1/29 19 68 , that (I) (we) last saw the deceased alive on 1/9 19 68 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Herbert J. Levickas, M.D.				23B. DATE SIGNED 1/30/68	
23C. PHYSICIAN'S NAME (Type) Dr. Herbert J. Levickas				23D. ADDRESS 5404 East Drive, Baltimore, Md. 21227	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 2-1-1968		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 31 1968			
25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-1218</u>
BIRTH NO. <u>68-1218</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>FLORENCE E. FEINOUR, XXXXXXXXXXXX</u>		2. DATE AND HOUR OF DEATH <u>1/28/68</u> <u>1:10 AM</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>LUTHERAN HOSPITAL OF MARYLAND</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Arbutus</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4713 Aldgate Green</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/26/87</u>	9. AGE (In years last birthday) <u>81</u> If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Clarence Windle</u>		
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>218-16-0928</u>		17. INFORMANT ADDRESS <u>Mrs. Florence Bishop, 4713 Aldgate Green 21227</u>		
18. <u>484 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory Failure due to Pneumonia with chronic brain syndrome</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. <u>493 X II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (if this hospital) attended the deceased from <u>1/21/68</u> 19 to <u>1/28/68</u> 19, that (I) last saw the deceased alive on <u>1/27/68</u> 19 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.				
23A. SIGNATURE <u>P. P. Joshi</u> M.D.		23B. DATE SIGNED <u>1/28/68</u>		23C. PHYSICIAN'S NAME (Type) <u>P. P. JOSHI</u> M.D.
23D. ADDRESS <u>730 ASHBURTON ST, BALTIMORE</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-31-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 31 1968</u>		25B. NAME OF REGISTRAR <u>P. P. Joshi</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Avenue</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-1219</u>
68-1219				CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Ramon Estrada</u> or <u>Raymond Estrada</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>1-30-68</u> <u>3:00 A.M.</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>43 South Baltimore</u> <u>GENERAL Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>NEW JERSEY</u> B. COUNTY <u>DUMONT</u> C. CITY OR TOWN <u>15 Colonial Park Drive</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <u>M.</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-4-02</u>	9. AGE (In years last birthday) <u>65</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>SEAMAN</u>		11. BIRTHPLACE (State or foreign country) <u>Puerto Rico</u>
13. FATHER'S NAME <u>John</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Quirk Funeral Home, 89 Engle St. N.J.</u>
18. <u>571.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>G-I bleeding</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>due to Esophageal Varices</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>deep Venous Embolism</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No.</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <u>he</u> (this hospital) attended the deceased from <u>1-28</u> 19 <u>68</u> to <u>1-30</u> 19 <u>68</u> , that <u>he</u> (we) last saw the deceased alive on <u>1-30</u> 19 <u>68</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Song Suck Chung</u> DEGREE				23B. DATE SIGNED <u>1-30-68</u>
23C. PHYSICIAN'S NAME (Type) <u>Song Suck Chung</u> DEGREE		23D. ADDRESS <u>1213 Light St.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>2-2-1968</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Garden State Crematory</u>
24D. LOCATION (City, town, or county) <u>North Bergen, New Jersey</u>		(State)		
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 31 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>

General Hospital
White
Pacific
3-4-42

108

10-

1-28
1-31

1000 1000 1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1220
BIRTH NO. 68-1220				CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) HELEN C GILLIAM		2. DATE AND HOUR OF DEATH 1/28/68 4:45 PM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 27-14		
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSP.		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 1019 W. COLD SPRING LANE		
5. SEX F	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-17-26	9. AGE (In years last birthday) 41
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? AMERICA		13. FATHER'S NAME John Zadocogny		
14. MOTHER'S MAIDEN NAME Mercedes Love		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. -		17. INFORMANT Thomas E Gilliam		
18. CAUSE OF DEATH		ADDRESS 1019 W Cold Spring Ln		
18. 593.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE Bilateral bronchopneumonia 5 DAYS (B) DUE TO, OR AS A CONSEQUENCE OF: Acute tubular necrosis with 5 WEEKS (C) UNDERLYING CAUSE uremia 200		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 603X II				
19A. DATE OF OPERATION 3/21/28/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Respiratory distress		20A. AUTOPSY? (Yes or No) yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) -		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -
22. I certify that (I) (this hospital) attended the deceased from 23/12/67 1967 to 1/28 1968 , that (I) (we) last saw the deceased alive on 1/28 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE [Signature]				23B. DATE SIGNED 1/28/68
23C. PHYSICIAN'S NAME (Type) NOUBAR DIDIZIAN M.D.				23D. ADDRESS UNION MEMORIAL HOSPITAL
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-1-68		24C. NAME OF CEMETERY OR CREMATORY Woodlawn
24D. LOCATION (City, town, or county) (State) Woodlawn Bk to Co Md		25A. DATE REC'D BY HEALTH DEPT. JAN 31 1968		
25B. NAME OF REGISTRAR Robert E. Fadden		25C. FUNERAL DIRECTOR Burgess Funeral Home Bk to Md		
25D. ADDRESS By [Signature]				

RECEIVED
JAN 10 1968

10 25-11-5

RECEIVED

✓

31 MAR 2

101 211 101 211 101 211

101 211 101 211

~~RECEIVED~~

RECEIVED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1221	
B-250		68-1221		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ALICE W. BIGHAM		2. DATE AND HOUR OF DEATH 1/28/68 7:10 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 44 Union Memorial Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 12-07			
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F 6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-19-98 9. AGE (In years last birthday) 69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? AMERICA	
13. FATHER'S NAME UNKNOWN MANN; Thomas		14. MOTHER'S MAIDEN NAME WINIFRED BANAHAN		15. Was Deceased Ever in U. S. Armed Forces? (Yes; no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 218523741		17. INFORMANT Thomas Bigham ADDRESS 1677 North Bournville Rd			
18. 412.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MASSIVE GI Hemorrhage (B) ASCVD - Renal failure DUE TO, OR AS A CONSEQUENCE OF: (C) Respiratory distress			
19A. DATE OF OPERATION 11/27/68 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Hemorrhage (GI)		20A. AUTOPT? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from 1/26/68 to 1/28/68 , that (I) (we) last saw the deceased alive on 1/28/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] DEGREE M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/28/68	
23C. PHYSICIAN'S NAME (Type) DR. ROBERT D. DIZIAN DEGREE M.D.		23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-1-68		24C. NAME OF CEMETERY or CREMATORY Parkwood 24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 31 1968		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR Burgess Funeral Home ADDRESS Baltimore Md	

2421 1042
2520 2421 0421
11-19-77
CHANDLER
WINTERED B. 2421

2421 1042
2520 2421 0421
11-19-77
CHANDLER
WINTERED B. 2421

MAINE (I. 2421)
HSCV - 2421 1042

2421 1042
HSCV - 2421 1042

2421 1042
HSCV - 2421 1042
2421 1042
HSCV - 2421 1042

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1222

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68- 1222

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Bull, George W.

2. DATE AND HOUR OF DEATH

1/28/68

8:45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Union Memorial Hosp.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐

NO ☐

E. STREET AND NUMBER

4515 Schenley Road.

5. SEX

M

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

02/22/11

9. AGE in years (last birthday)

56

If Under 1 Yr. Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Chemical Regulator, City Water Works

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Jesse Curtis Bull

14. MOTHER'S MAIDEN NAME

Pearl Edna Cattrider

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

215 017120

17. INFORMANT

ADDRESS

Dorothy R. Bull 4515 Schenley Rd

18.

486 X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

Pneumonia

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

10 days

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) W. K. W.

493 X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/18/68 to 1/28/68, that (I) (we) last saw the deceased alive on 1/28/68 and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

H. F. HOLCOMB, DR.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1/28/68

23C. PHYSICIAN'S NAME (Type)

H. F. HOLCOMB, DR.

23D. ADDRESS

THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1-31-68

24C. NAME OF CEMETERY or CREMATORY

Druid Ridge

24D. LOCATION

Pikesville, Balto Co Md

25A. DATE REC'D BY HEALTH DEPT.

JAN 31 1968

25B. NAME OF REGISTRAR

Robert E. Fairbank

25C. FUNERAL DIRECTOR

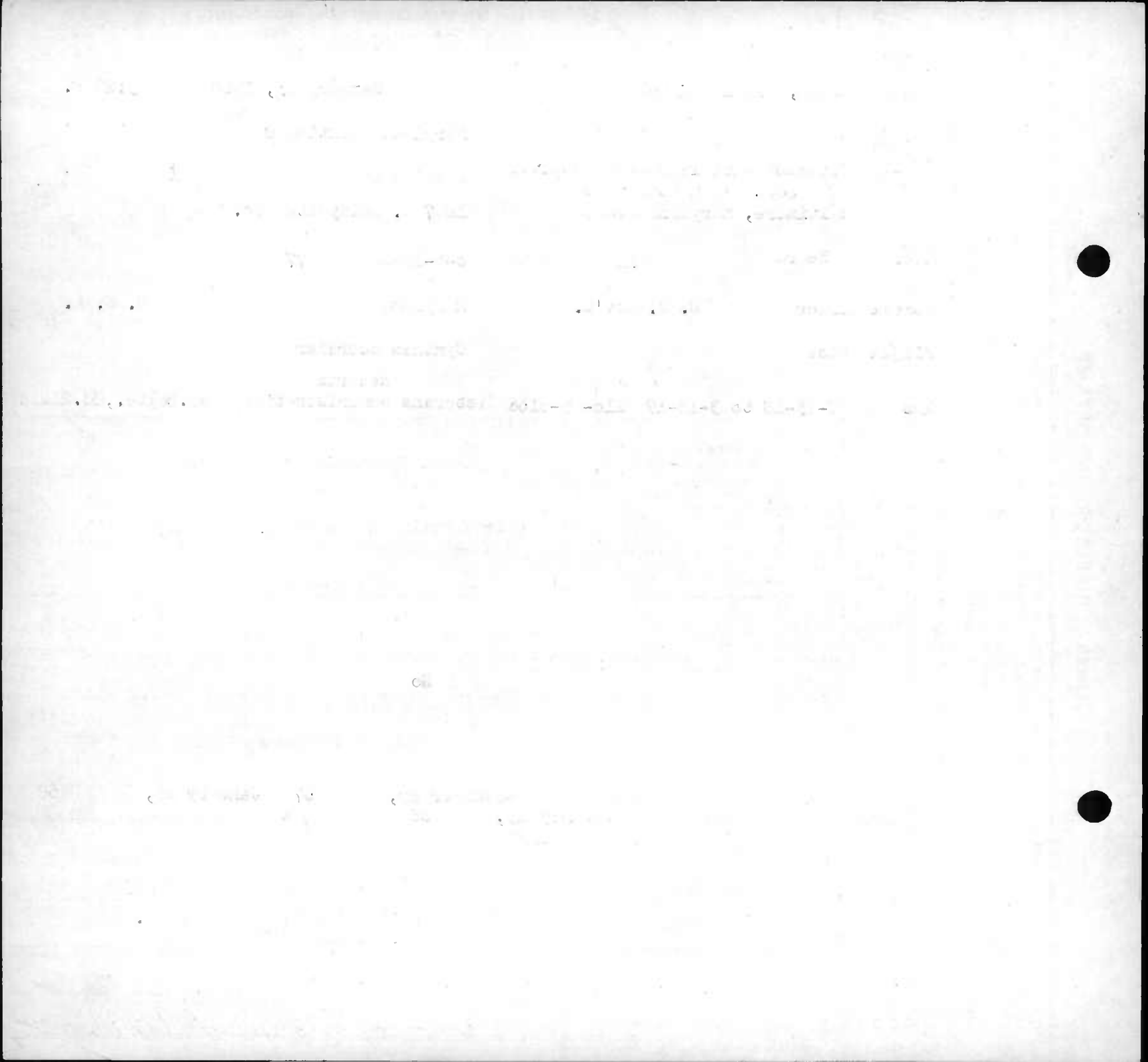
Burger Funeral Home Balto Md

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

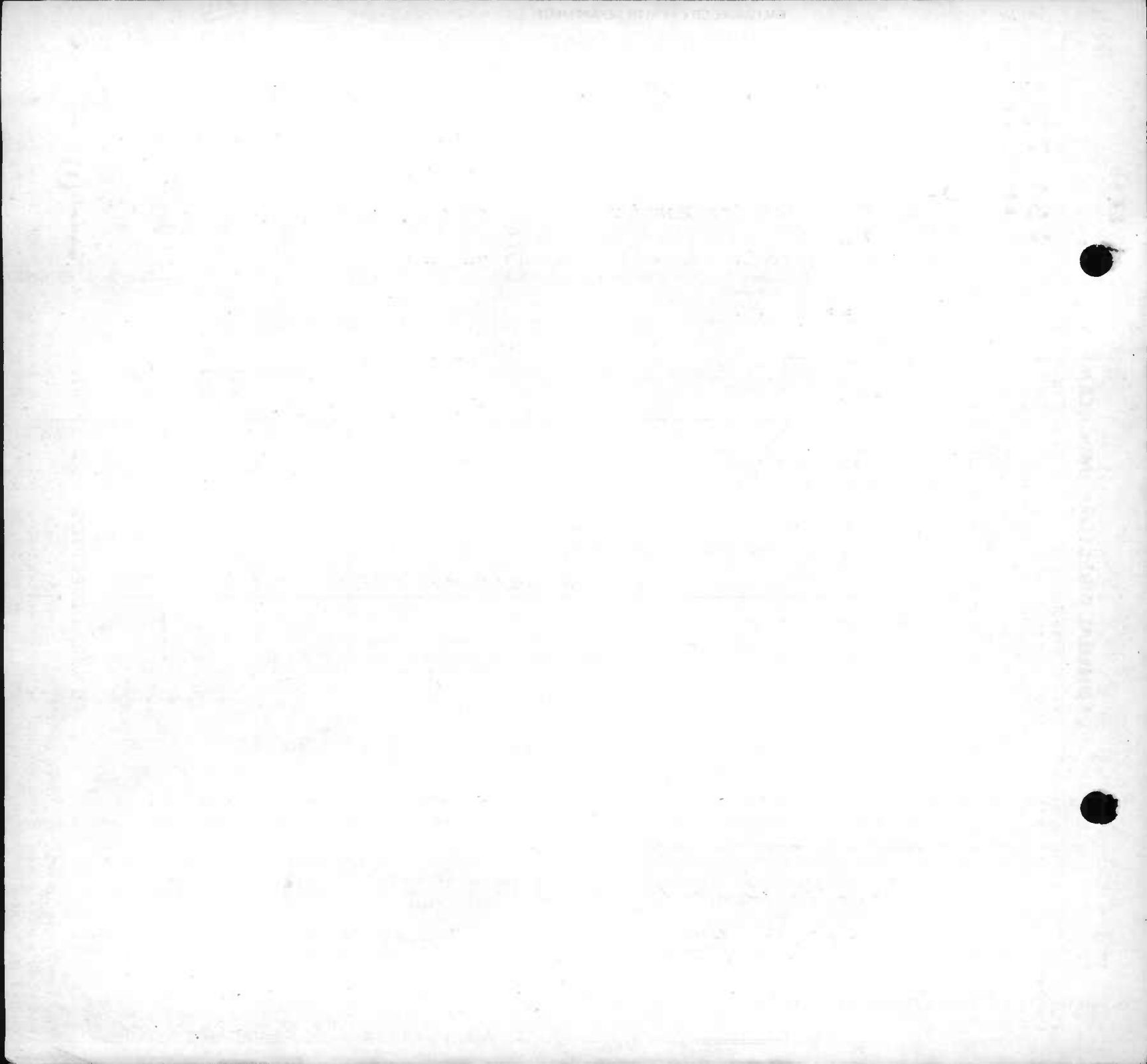
H-200		68-1223		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1223	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) HOUSE, WILLIAM HENRY			
2. DATE AND HOUR OF DEATH January 25, 1968				3:20 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 1807 W. Lafayette Ave.							
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-6-1890	9. AGE (In years lost birthday) 77	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Worker		10B. KIND OF BUSINESS OR INDUSTRY U. S. Gov't.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Elijah House				14. MOTHER'S MAIDEN NAME Cynthia Scoraler			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 7-15-18 to 3-13-19		16. SOCIAL SECURITY NO. 116-05-6166		17. INFORMANT Records		ADDRESS Veterans Administration Hosp. Balto., Md. 21218	
18. CAUSE OF DEATH 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Cardiovascular disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 420.1 II							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that 10 (this hospital) attended the deceased from November 19, 1967 to January 25, 1968 , that (X) (we) last saw the deceased alive on January 25, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Monica M. Buckley				23B. DATE SIGNED 1/26/68		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) Monica M. Buckley				23D. ADDRESS VA Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-29-68		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 31 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Arlington Shaffer		ADDRESS 1727 N. Mount	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-550 68-1224 CERTIFICATE OF DEATH				REG. NO. 68-1224	
BIRTH NO.			1. NAME OF DECEASED (Type or Print)		
			Bynum, Geraldine E.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			2. DATE AND HOUR OF DEATH		
			1-23-68 11:45 A. M.		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		
The Johns Hopkins Hospital			Maryland Baltimore		
5. SEX			C. CITY OR TOWN		
Female			Baltimore		
6. RACE			D. INSIDE CITY LIMITS?		
Negroid			YES <input type="checkbox"/> NO <input type="checkbox"/>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			E. STREET AND NUMBER		
			2032 N. Cecil Ave.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			9. AGE (In years last birthday)		
Unemployed			7-10-47 20		
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		
			Baltimore, Md.		
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Joseph Bynum					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			14. MOTHER'S MAIDEN NAME		
			Sarah Ewell		
16. SOCIAL SECURITY NO.			17. INFORMANT		
			Sarah Bynum		
			ADDRESS		
			Same		
18. 432X I			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			Cerebral Edema		
ANTECEDENT CAUSES			(B) ANOMIA OF CARDIAC ARREST		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			DUE TO, OR AS A CONSEQUENCE OF:		
			4 HOURS		
			(C) IDIOPATHIC MYOCARDITIS		
			DUE TO, OR AS A CONSEQUENCE OF:		
			8 YEARS		
431X II			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
0					
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
No			No		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED		
			While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1-23 1968 to 1-23 1968, that (I) (we) last saw the deceased alive on 1-23 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE					23B. DATE SIGNED
Major W. Bradshaw					1-23-68
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS
MAJOR W. BRADSHAW					Johns Hopkins Hospital
24A. BURIAL CREMATION, REMOVAL (Specify)					24B. DATE
Burial					1-27-68
24C. NAME OF CEMETERY OR CREMATORY					24D. LOCATION (City, town, or county) (State)
Mt. Auburn					Baltimore Md.
25A. DATE REC'D BY HEALTH DEPT.					25B. NAME OF REGISTRAR
JAN 31 1968					Robert E. ...
25C. FUNERAL DIRECTOR					ADDRESS
Arlington ...					1727 N. ...



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-1225

BIRTH NO.

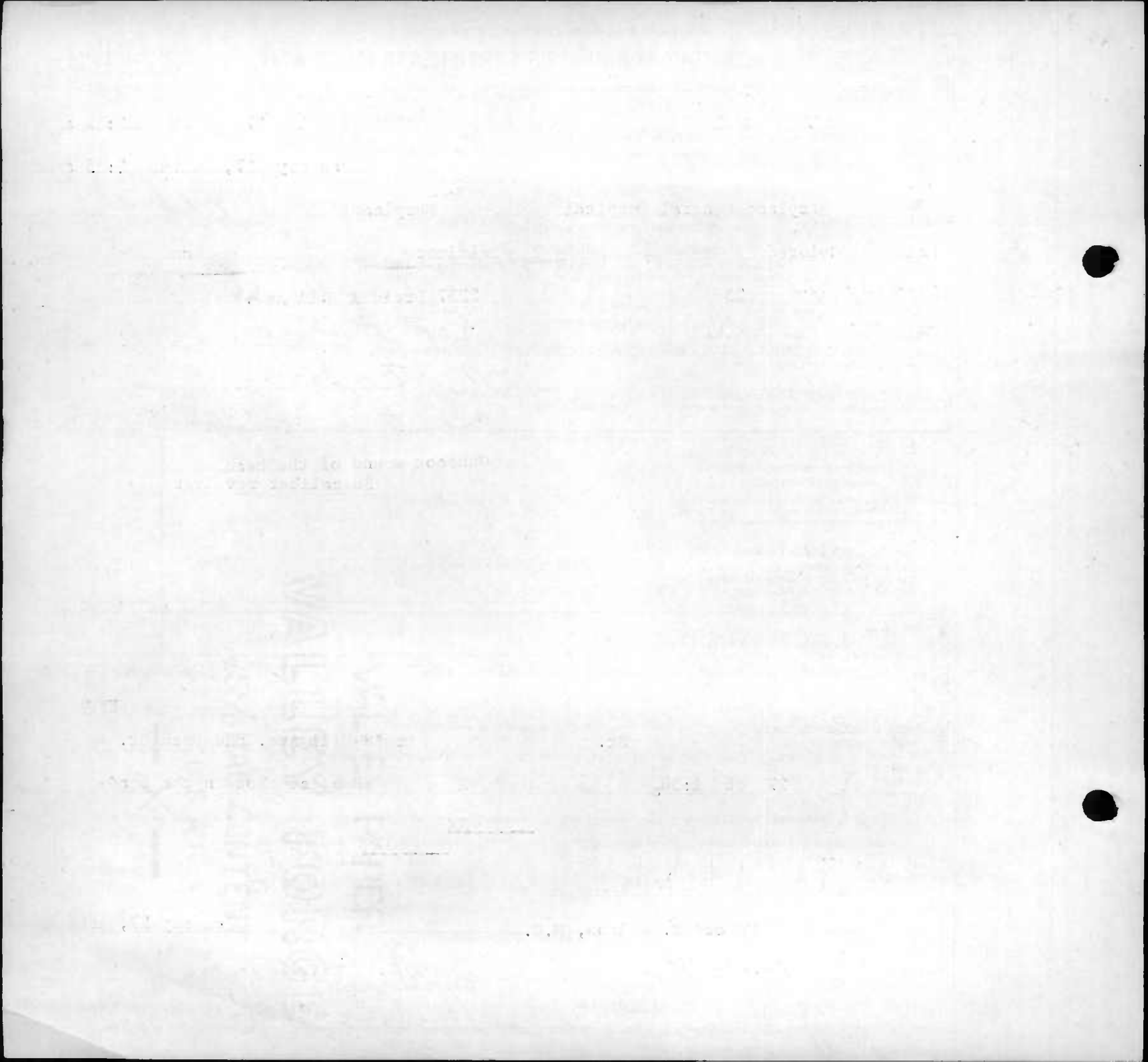
1. NAME OF DECEASED (Type or Print) WELDON CARR		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 27 68 2:15 a M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital (If not in hospital or institution, give street address or location)		3. DATE PRONOUNCED DEAD Month Day Year Hour January 27, 1968 2:15 a M.	
6. SEX Male	7. RACE Colored	5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 14-03	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH Aug. 3, 1944	10. AGE (In years last birthday) 23	E. STREET AND NUMBER 2237 Druid X Hill Ave.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		13. FATHER'S NAME Robert Carr	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Myrtle Jolley	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Robert Carr		ADDRESS 1736 N. Bentwater St.	

19. E 965 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Gunshot wound of the head (A) IMMEDIATE CAUSE 38 caliber revolver DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) YES	

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) St.		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Druid Hill Ave. and Paca St. 17-01	
22D. TIME OF INJURY (APPROX.) Month Day Year Hour 1 27 68 1:50 a		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject shot in the head	

23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D.						DATE SIGNED January 27, 1968	
---	--	--	--	--	--	--	--

24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-30-68		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Ch.		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 31 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Arbutus Mem. Ch.		ADDRESS 1727 N. Mount St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				68- 1226	
BIRTH NO. W-325		68- 1226		REGISTERED NO. 68- 1226	
CERTIFICATE OF DEATH					
M.E. CASE NO.		2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) WATSON, WILLIAM		JANUARY 29, 1968 1:00P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL		A. STATE MARYLAND			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 102 FOREST DRIVE 21228			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED	8. DATE OF BIRTH 6/16/96	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIROGOVERNMENT		10B. KIND OF BUSINESS OR INDUSTRY FT DEITRICH		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN WATSON		14. MOTHER'S MAIDEN NAME CHRISTINE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. 215-03-2737		17. INFORMANT William W. Watson, 422 Gun Road	
				ST. AGNES HOSPITAL RECORDS	
				Baltimore, Maryland 21227	
18. 429.0 I		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) Pneumonia, Hepatitis			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(B) Chronic Passive Congestion of the liver			
ANTECEDENT CAUSES		(C) Cardiomegaly			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
18. 434.4 II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 21		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JANUARY 11 19 68 to JANUARY 29 19 68 , that (I) (we) last saw the deceased alive on JANUARY 29 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. Alvarez		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) M. ALVAREZ		23D. ADDRESS BALTO, MD 21229 ST. AGNES HOSP; CATON & WILKENS AVES.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 2-1-68	24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 31 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS 4101 Edmonds n Avenue Witzke F. D., Balto., Md. 21229	

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

68-1227

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-1227

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) DOROTHY ALLEN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> January 25, 1968		Hour 9:32 P.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 3399 JOHNS HOPKINS HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year January 25, 1968		Hour 9:32 P.
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 7-04				
6. SEX Female	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore
9. DATE OF BIRTH 11-22-1905		10. AGE (In years lost birthday) 62	E. STREET AND NUMBER 1736 Eager Street	
11. BIRTHPLACE (State or foreign country) Sax. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Henry Brooks	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		14B. KIND OF BUSINESS OR INDUSTRY At home	15. MOTHER'S MAIDEN NAME UNKNOWN	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. NONE	18. INFORMANT ADDRESS Delone's Street 1736 E. Eager St.	
19. 412.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C) DUE TO, OR AS A CONSEQUENCE OF:		
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held on <u>Inquiry</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-29-68				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-30-68	24C. NAME OF CEMETERY or CREMATORY Carver Memorial Pk.	24D. LOCATION (City, town, or county) (State) Laurel, Md.
25A. DATE REC'D BY HEALTH DEPT. JAN 31 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Randolph J. Collick 2431 E. Oliver St.

11-22-1962

221 1/2

Barro Colorado

no

W. J. B.

As above

Henry B. Smith

unknown

name - ~~Barro Colorado~~ 11-22-1962

W. J. B.

()

Barro Colorado

Barro Colorado

1-20-68

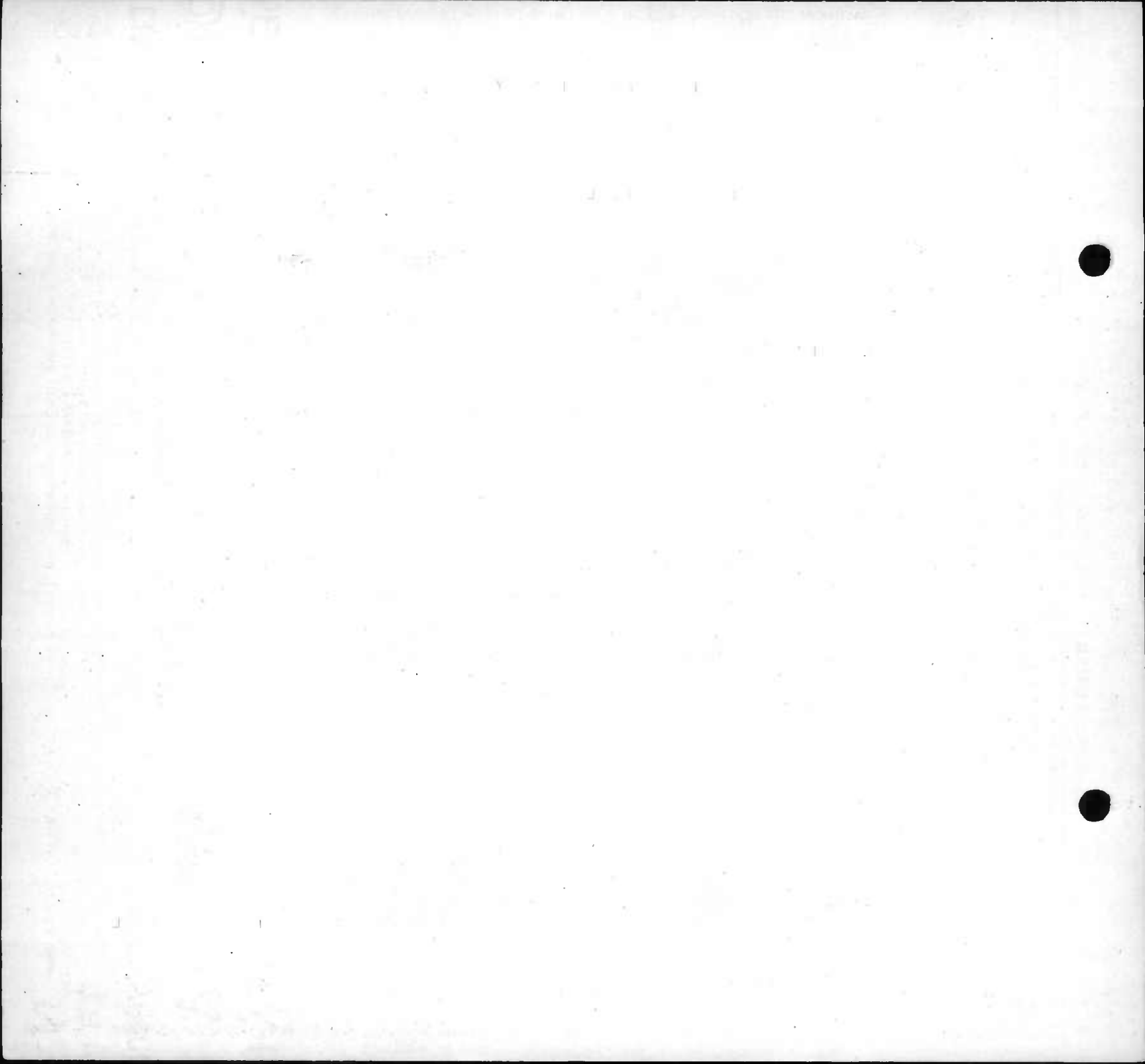
Vol.

Barro Colorado

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

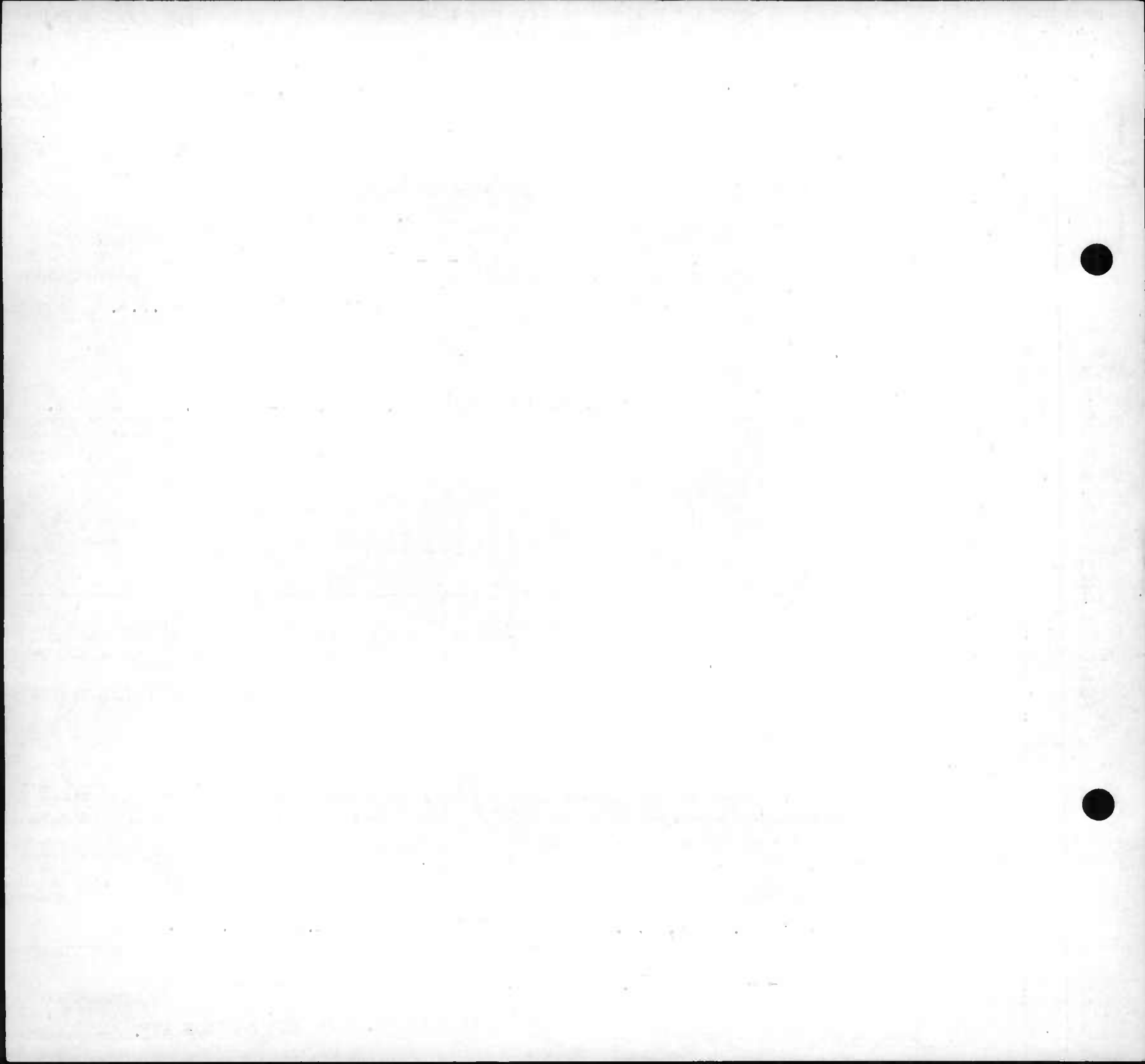
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1228
BIRTH NO. 68-1228				CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) ELIZABETH LINDSAY		2. DATE AND HOUR OF DEATH 1-22-68 1:40 P		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 7-05 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> EX <input type="checkbox"/> E. STREET AND NUMBER 831 N. WOLFE STREET		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-4-1915	9. AGE (In years last birthday) 52
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY Private		11. BIRTHPLACE (State or foreign country) Woodward, S.C.
13. FATHER'S NAME JOHN CHISHOLM		14. MOTHER'S MAIDEN NAME ROSE JORDAN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 237-14-0062		17. INFORMANT Robert Lindsay 831 N. Wolfe St.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 331X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: probable CVA (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 1/22/68 to 1/22/68, that (I) (we) lost saw the deceased alive on 1/22/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Philip Reid				23B. DATE SIGNED 1/22/68
23C. PHYSICIAN'S NAME (Type) PHILIP REID		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-27-68		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. JAN 31 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR ADDRESS Randolph J. Collick 243 E. Oliver St.



FUNERAL DIRECTOR: IMPORTANT

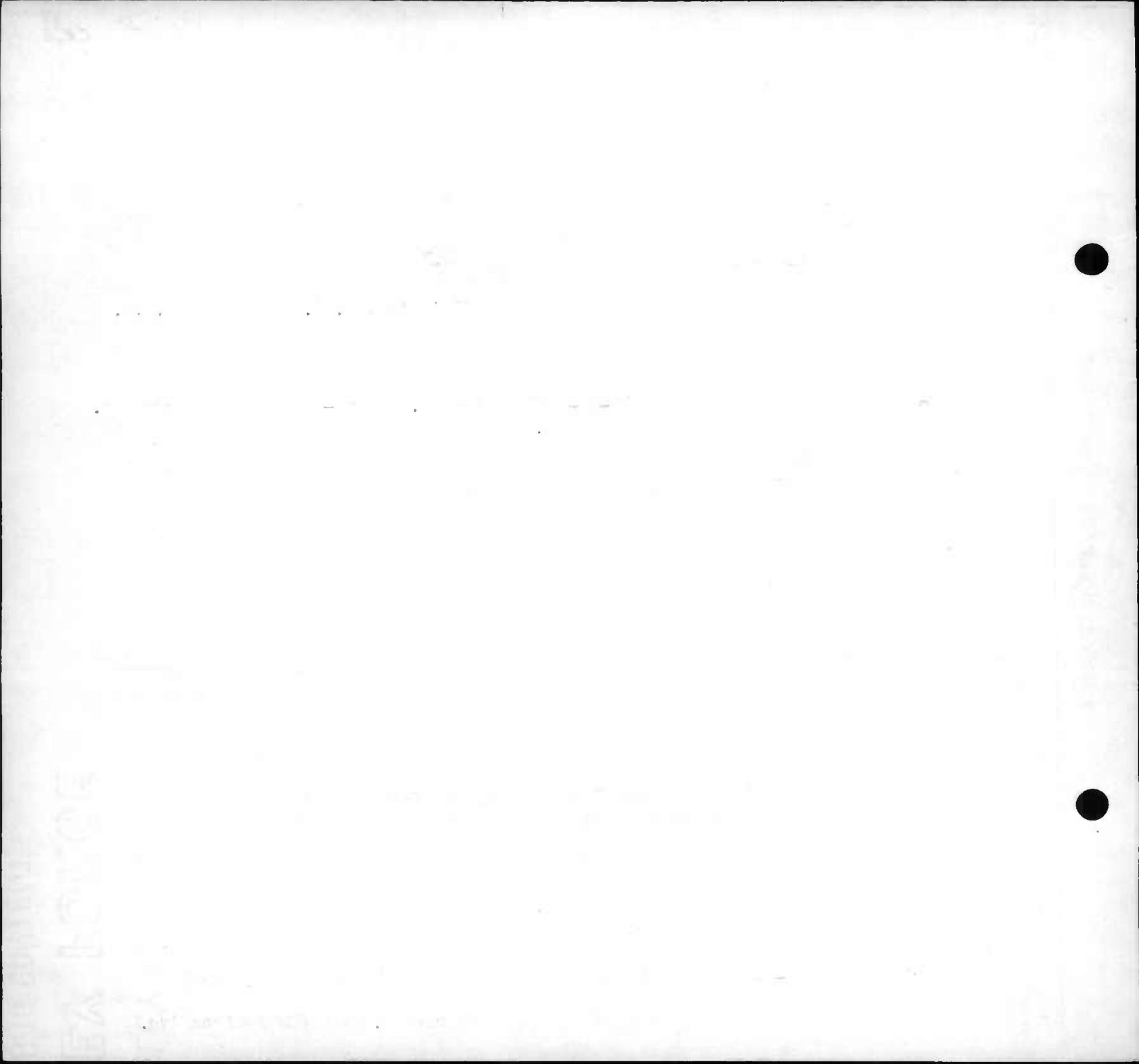
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-- 1229		BALTIMORE CITY HEALTH DEPARTMENT		68-- 1229	
CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JOHN C. WOODLAND		JANUARY 28, 1968 9:30 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
00 1205 MYRTLE AVENUE				MARYLAND	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		1112 N. BENTALOU STREET			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	
MALE	COLORED	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12-28-1916	51	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
DENTIST		SELF EMPLOYED		BALTIMORE, MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
CHARLES R. WOODLAND		HELEN RUSSELL		U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
YES		WW II		4705-12-8539	
				LETTIE C. WOODLAND - 1112 N. BENTALOU ST.	
18. 412.0 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		4 yrs	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Coronary artery sclerosis			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		7 yrs	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Hypertensive cardio-vascular disease			
420.1 II		(C) Overt, exogenous			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1961 to 1968, that (I) (we) lost saw the deceased alive on 1.25.1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
James D. Carr				1.30.68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
JAMES D. CARR, M.D.				1427 MADISON AVE., BALTO., MD.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		2-1-68		BALTIMORE NATIONAL	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 31 1968		R. B. E. Taylor		CHARLES R. LAW 802 MADISON AVE.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1230		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68-1230	
BIRTH NO.					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>DANCY, Callie E</u>			2. DATE AND HOUR OF DEATH <u>1-29-1968</u> <u>1</u> <u>1</u> P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>91 MONTEBELLO STATE HOSP. BALTIMORE, MD</u>			A. STATE <u>MD</u> B. COUNTY <u>Poplar Grove</u>		
C. CITY OR TOWN (If outside city limits, write RURAL and give town ship) <u>Baltimore</u>			D. STREET ADDRESS (If rural, give location) <u>#16</u>		
5. SEX <u>F</u>	6. RACE <u>Colored</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED</u> , DIVORCED (specify)	8. DATE OF BIRTH <u>5/5/85</u>	9. AGE (In years last birthday) <u>82</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Wilmington, N. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>FREDERICK Brown</u>		14. MOTHER'S MAIDEN NAME <u>Mahala NEWTON</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-16-8953</u>		17. INFORMANT ADDRESS <u>Irma O. Dancy - 2315 Poplar Grove St.</u>	
18. <u>250.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>MULTIPLE CEREBRAL EMBOLISM</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerosis generalized</u> <u>Diabetes mellitus</u>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
19. DATE OF OPERATION <u>260X</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>II</u>		
20A. AUTOPSY? (Yes or No) <u>No</u>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/23/64</u> to <u>1-29-1968</u> , that (I) (we) lost saw the deceased alive on <u>1-29-1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Young Lea Law</u> M.D.			23B. DATE SIGNED <u>1/29/68</u>		
23C. PHYSICIAN'S NAME (Type) <u>Young Lea Law</u> M.D.			23D. ADDRESS <u>Montebello State Hosp. Balt, MD</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>2-2-68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial Park</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 31 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Charles R. Law 802 Madison Ave.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Released On Approval for the Medical Examiner's Office by Dr. Contostavlos

MEDICAL CERTIFICATION

BIRTH NO. 68-1231				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1231			
1. NAME OF DECEASED (Type or Print) CLANTON, FRED J.				2. DATE AND HOUR OF DEATH 1/25/68 6:40 A.M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 33 The Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore							
5. SEX Male 6. RACE Negroid 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 8-31-12 9. AGE (In years last birthday) 55				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			
11. BIRTHPLACE (State or foreign country) Vaughan, N.C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Samuel B. Clanton				14. MOTHER'S MAIDEN NAME Ella Thorne							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes W.W.II				16. SOCIAL SECURITY NO. 213-07-5793				17. INFORMANT Celia Clanton ADDRESS 513 Main St. Balto. Md. 21222			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) E880K				19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Recurrent Pulmonary Embolism one day				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. 900.0 II				(B) DUE TO, OR AS A CONSEQUENCE OF: Thrombophlebitis @ thigh + leg 3 days							
(C) DUE TO, OR AS A CONSEQUENCE OF: Inactivity from paraparesis 9 days				(D) DUE TO, OR AS A CONSEQUENCE OF: Paraparesis from C-5 cord trauma 9 days							
21A. DATE OF OPERATION 2				21B. CONDITION FOR WHICH OPERATION WAS PERFORMED II				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 00-00			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 1 16 68 ?				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>				21F. HOW DID INJURY OCCUR? Patient fell down 14 steps			
22. I certify that (I) (this hospital) attended the deceased from 1/16 to 1/25 19 68 , and that in my (aur) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Richard Parry MD				23B. DATE SIGNED 1/25/68							
23C. PHYSICIAN'S NAME (Type) Dr. Richard Parry, M.D.				23D. ADDRESS The Johns Hopkins Hospital							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 1-29-68				24C. NAME OF CEMETERY OR CREMATORY National Cemetery			
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland											
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1968				25B. NAME OF REGISTRAR Randolph J. Collick				25C. FUNERAL DIRECTOR ADDRESS 2431 E. Oliver St.			

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

68- 1232

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 1232

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LOUISE PAULINE WARTHER LOUISE WARTHER		DATE OF DEATH Known <input type="checkbox"/> Estimated <input checked="" type="checkbox"/> January 28, 1968 11 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 99 Maryland General Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year January 28, 1968 11:25 A.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 13-03	
9. DATE OF BIRTH MAY 14, 1907		10. AGE (In years last birthday) 60	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		14B. KIND OF BUSINESS OR INDUSTRY At Home	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO.	
19. 492x1		CAUSE OF DEATH Pulmonary emphysema with cor pulmonade (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) Yes	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED January 29, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/1/68	
24C. NAME of CEMETERY or CREMATORY St. Paul's Lutheran		24D. LOCATION (City, town, or county) (State) Violetville Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 31 1968		25B. NAME OF REGISTRAR Robert E. Finkbeiner	
25C. FUNERAL DIRECTOR HENRY SANDER & SONS INC.		ADDRESS BALTIMORE MARYLAND 21213	

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

68- 1233

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 1233

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES WADDELL		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year January 24, 1968		Hour M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 1425 E. Preston Street		3. DATE PRONOUNCED DEAD Month Day Year January 24, 1968		Hour M. 3:45 P.
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 10-01				
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH Oct 4 1907	10. AGE (In years lost birthday) 60	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	E. STREET AND NUMBER 1425 E. Preston Street	
11. BIRTHPLACE (State or foreign country) N. Carolina		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME John T. Waddell
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Maggie Perry
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.		18. INFORMANT Jane Walker 611 South St. Rocky Mt. Co.
19. 412.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED January 25, 1968				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan 30/68		24C. NAME of CEMETERY or CREMATORY Mt Auburn Cem.
24D. LOCATION (City, town, or county) Westport Md		24E. NAME of REGISTRAR Robert E. Fisher, MD		
25A. DATE REC'D BY HEALTH DEPT. JAN 31 1968		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Frank T. E. Lukers 1129 N. Carroll

John P. Mohr
Manager
San Antonio on Santa Fe

Oct 1, 1907
T. L. Smith
Manager

Transferred to Santa Fe
Guest Station 1907

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RUTH PRIOLA		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 1 28 68 8:55 am.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 317 S. Central Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour January 28 1968 8:55 a.m.	
6. SEX M Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH APRIL 16/28		10. AGE (In years lost birthday) 39	
11. BIRTHPLACE (State or foreign country) BROOKLYN N. Y.		12. CITIZEN OF U.S.A.	
13. FATHER'S NAME GEORGE PRIOLA		14. MOTHER'S MAIDEN NAME EDITH CUMMING	
15. USUAL OCCUPATION (Give kind of work done in last working life, even if retired) HOUSEWIFE		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		18. SOCIAL SECURITY NO. NONE	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Undetermined after autopsy and Toxicological examination		20. CAUSE OF DEATH Undetermined after autopsy and Toxicological examination	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
23. DATE OF OPERATION 2		24. CONDITION FOR WHICH OPERATION WAS PERFORMED	
25. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
27. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		28. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
29. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		30. HOW DID INJURY OCCUR?	
31. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
32. ACTUAL SIGNATURE Edward F. Wilson EXAMINER'S NAME (Type)		33. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
34. DATE REC'D BY HEALTH DEPT. JAN 31 1968		35. NAME OF REGISTRAR Robert E. Taylor, M.D.	
36. DATE OF BURIAL CREMATION, REMOVAL (Specify) BURIAL		37. DATE 1/31/68	
38. NAME OF CEMETERY or CREMATORY LOUDON PARK		39. LOCATION (City, town, or county) (State) BALTO. Md.	
40. FUNERAL DIRECTOR Frank Della Voce		41. ADDRESS 322 S. HIGH ST.	

MEMORANDUM FOR THE RECORD

TO :

FROM :

SUBJECT :

DATE :

BY :

FOR :

RE :

NOTE :

REFERENCE :

ATTACHMENT :

REMARKS :

APPROVAL :

SIGNATURE :

DATE :

BY :

FOR :

RE :

NOTE :

REFERENCE :

ATTACHMENT :

REMARKS :

APPROVAL :

SIGNATURE :

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1235

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 1235

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Annelsey Bond Baugh

2. DATE AND HOUR OF DEATH

January 28, 1968 10 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

90 Long Green Nursing Home

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

Long Green Nursing Home

5. SEX

F

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

1/2/1884

9. AGE (In years
last birthday)

84

If Under 1 Yr.

Months: Days: Hours: Min.

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Rockville, Md.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Beverley W. Bond

14. MOTHER'S MAIDEN NAME

Elizabeth Lumsden

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

212-36-2416

17. INFORMANT

823 Jackson Ave.
Frederick H. Baugh, Jr., N. Augusta, S.C.

18. 412.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

ASCVD

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

5 yrs

422.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

White At ☐
Work

Not White
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/20/44 to 1/28/68
that (I) (we) last saw the deceased alive on 1/27/68 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Francis W. Gluck

DEGREE

Attending
Phys. ☒

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

1/24/68

23C. PHYSICIAN'S
NAME (Type)

Francis W. Gluck

DEGREE

23D. ADDRESS

100 W. University Pkwy.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1/30/68

24C. NAME OF CEMETERY or CREMATORY

Druid Ridge

24D. LOCATION

(City, town, or county)

(State)

Pikesville, Balto. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 31 1968

25B. NAME OF REGISTRAR

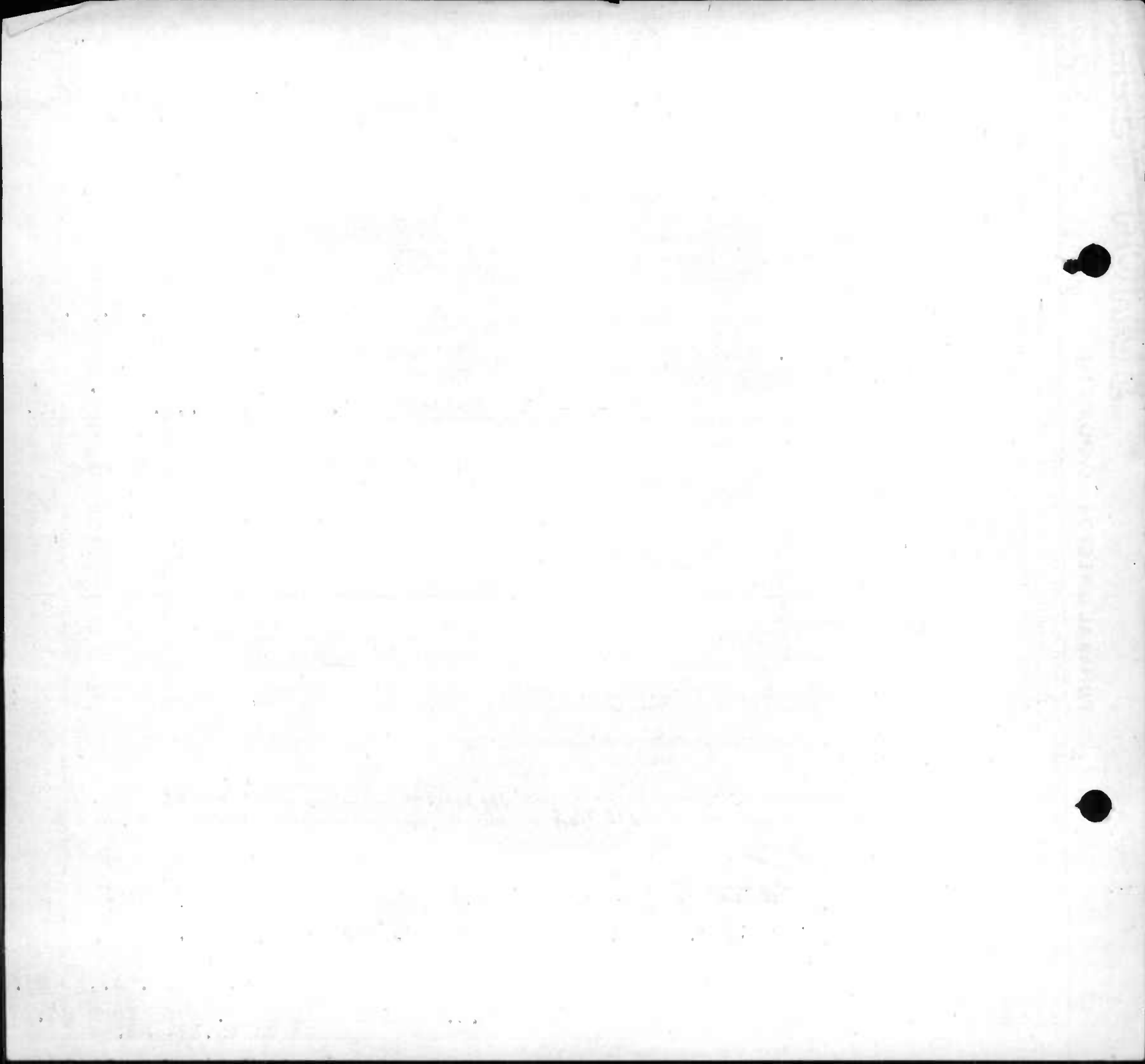
Robert E. Farber

25C. FUNERAL DIRECTOR

H. W. Jenkins & Sons Co. 4905 York Rd.

ADDRESS

Balto. Co., Md.



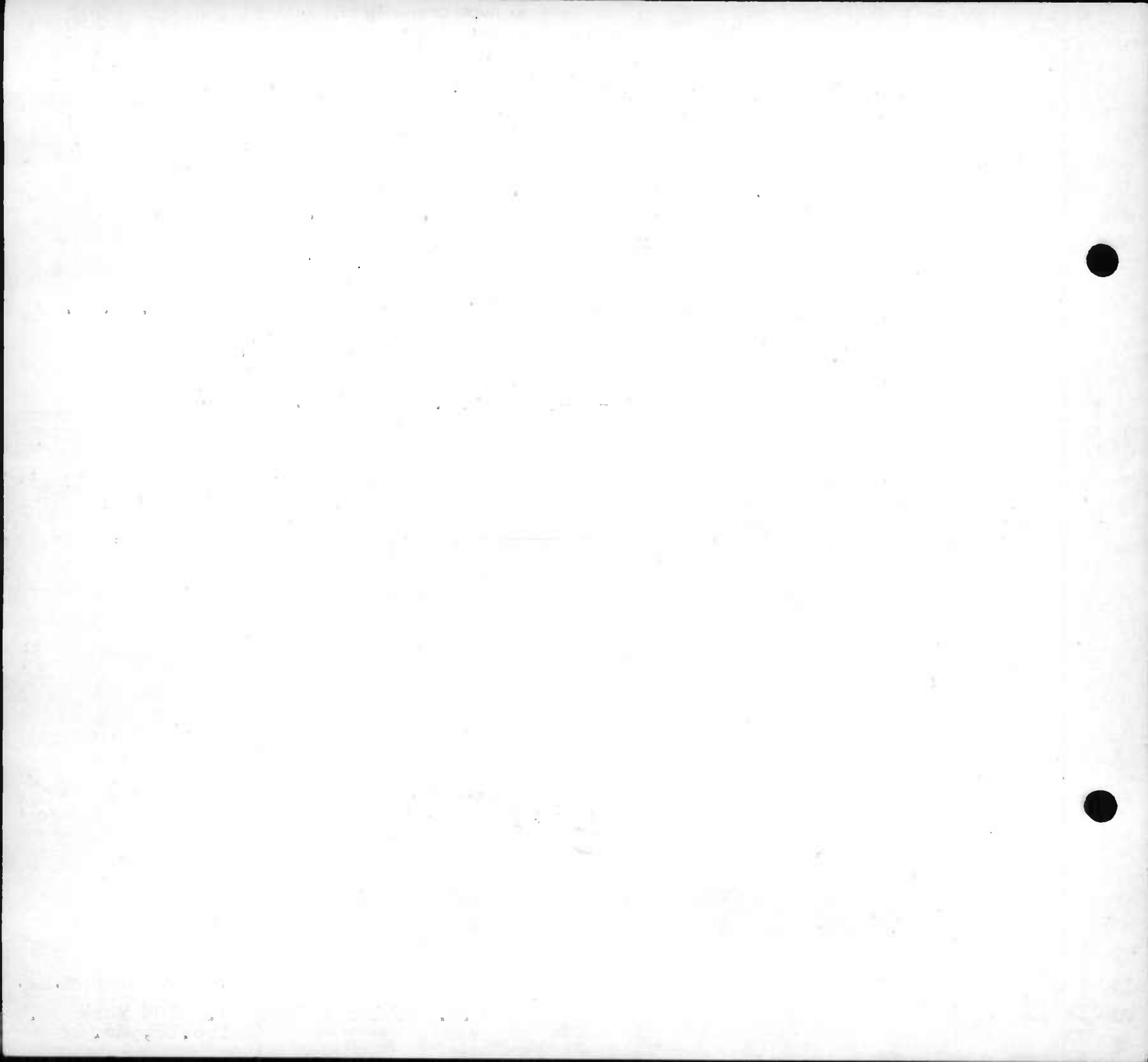
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1236 BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68-1236

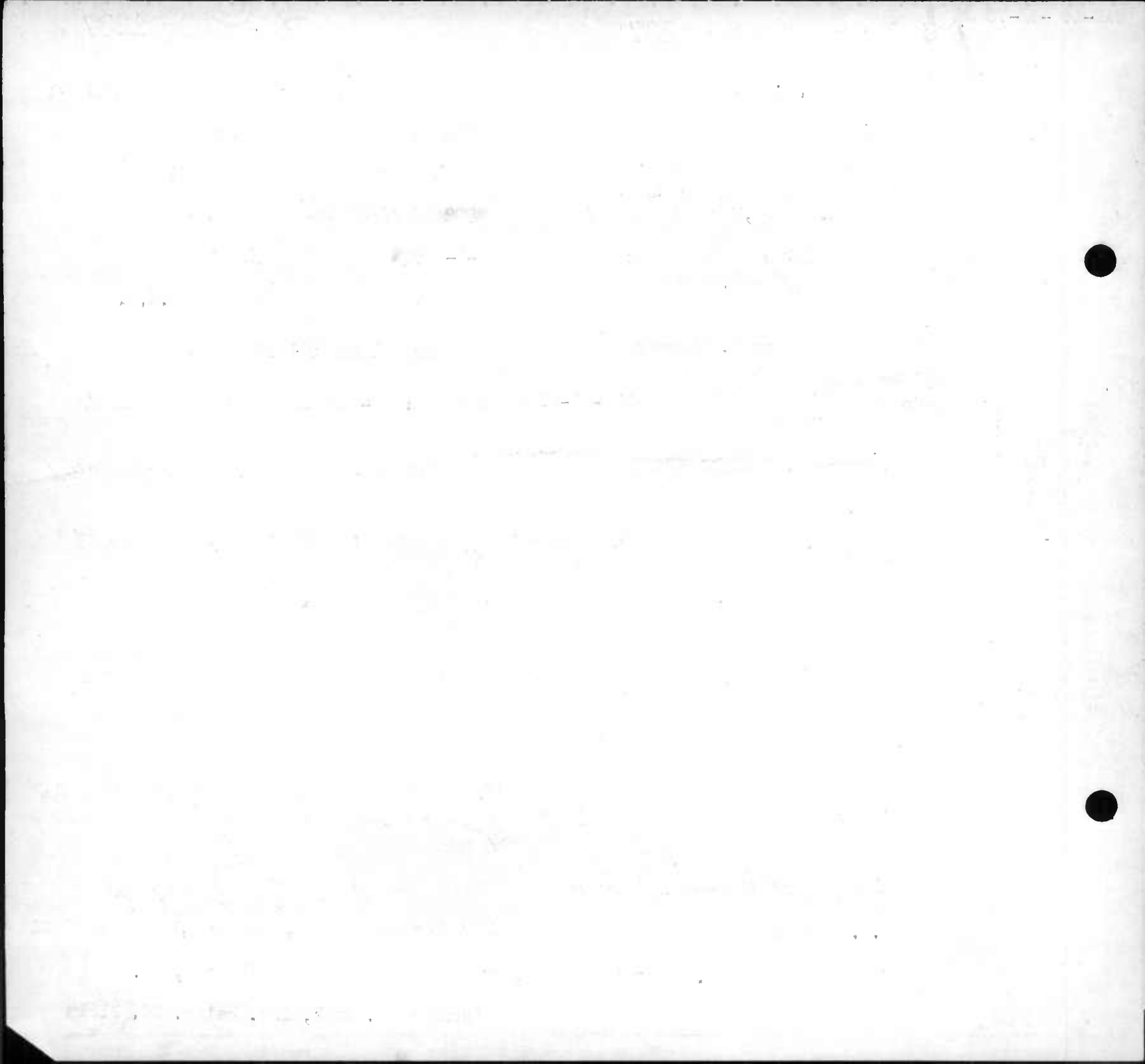
BIRTH NO.		1. NAME OF DECEASED (Type or Print) FRED BRUCE SMITH		2. DATE AND HOUR OF DEATH 1/29/68 7⁰⁰ P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2 W. University Pkwy.				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 12-01 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2 E. 39th St.	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/9/1897	9. AGE (In years lost birthday) 70
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10B. KIND OF BUSINESS OR INDUSTRY Medicine		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Joseph W. Smith				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 216-46-7247	
17. INFORMANT Mrs. Annabelle L. Smith				ADDRESS (Same)	
18. 410.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. several minutes (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____					
19. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED No 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) No		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from Jan 1968 19 to 1-29-1968 , that (1) (we) lost saw the deceased alive on 1-29-1968 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Paul G. Mullan MD				23B. DATE SIGNED 29 Jan 68	
23C. PHYSICIAN'S NAME (Type) PAUL A. MULLAN				23D. ADDRESS 2 W. UNIVERSITY PKWAY BALT IC	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/1/68		24C. NAME OF CEMETERY or CREMATORY Westminster	
24D. LOCATION (City, town, or county) (State) Westminster, Carroll Cty. Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 31 1968			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

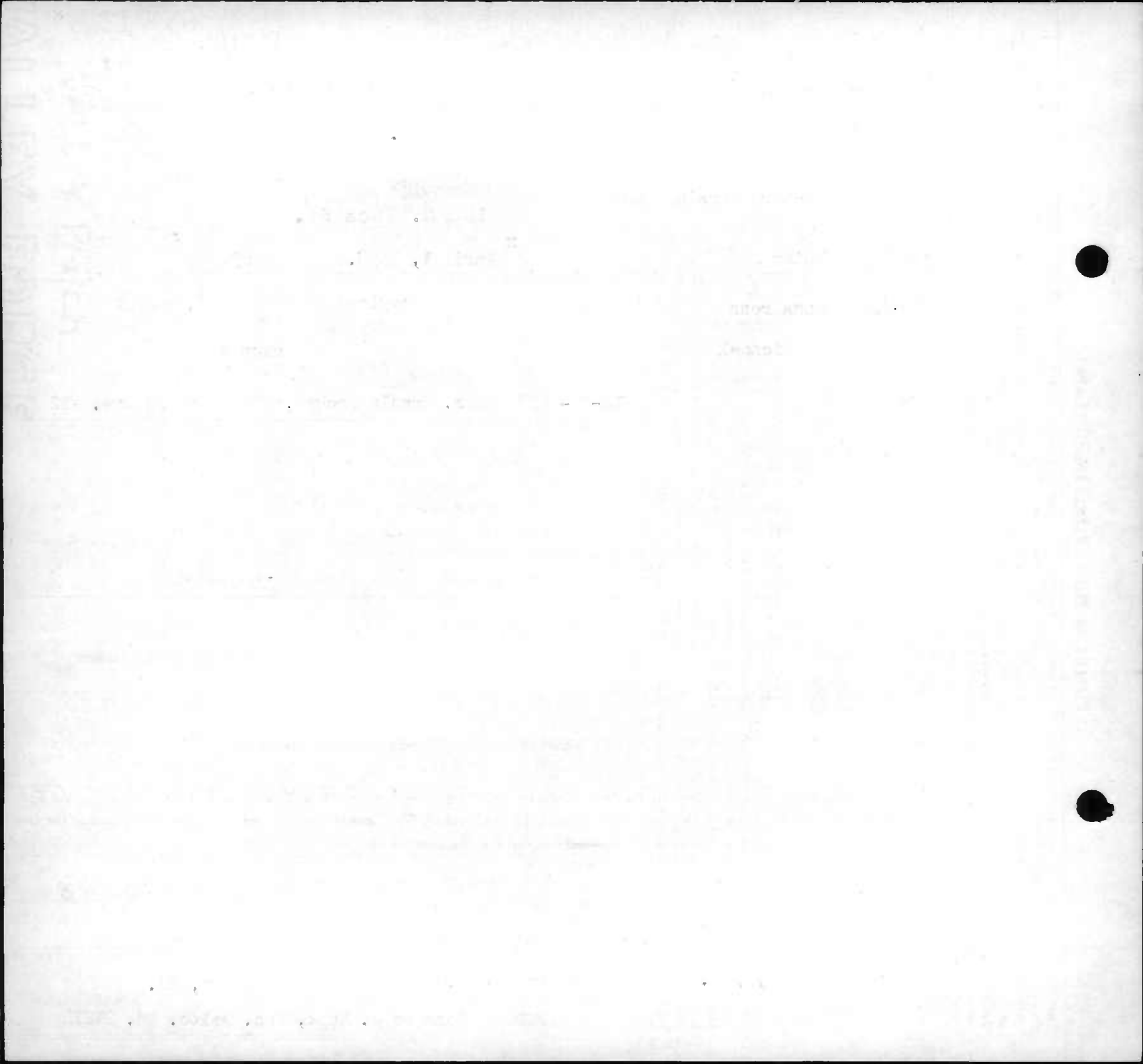
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1237	
BIRTH NO. 68-1237		BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type or Print) Grace C. Williams		2. DATE AND HOUR OF DEATH 1/30/68 10 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore Co. C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 8902 Harford Road 21234	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-1-1876
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 91 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James H. Simpson		14. MOTHER'S MAIDEN NAME Mary Ellen Hubbard	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-09-2172D	17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 6-99.0 I CAUSE OF DEATH (A) IMMEDIATE CAUSE Sepsis DUE TO, OR AS A CONSEQUENCE OF: (B) urinary tract infection DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 4 days			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 609X II			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 1/29/68 19 68 to 1/30 19 68 , that (I) (we) last saw the deceased alive on 1/30 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE E. M. Levinsohn, M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED 1/30/68
23C. PHYSICIAN'S NAME (Type) E.M. Levinsohn		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Maryland 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 2/2/68.	24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. JAN 31 1968		25B. NAME OF REGISTRAR Robert E. Feltman	25C. FUNERAL DIRECTOR ADDRESS Leona rd J. Ruck, Inc. Balto. Md. 21214



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-1238</u>
BIRTH NO. <u>68-1238</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Amelia Lesker</u>		2. DATE AND HOUR OF DEATH <u>1/30/68</u> <u>9³⁵</u> <u>A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Century Nursing Home</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>4-02</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>102 N. Paca St.</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 1, 1898.</u>	9. AGE (In years lost birthday) <u>69</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Seamstress</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Michael</u>		14. MOTHER'S MAIDEN NAME <u>Frances</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-03-9497</u>		17. INFORMANT ADDRESS <u>Mrs. Ursula Rockel, 6913 Holabird Ave. #22</u>
18. <u>412.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <u>Cardio-Respiratory Failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Congestive Heart Failure</u> <u>Arteriosclerotic C.V.D.</u> <u>Terminal Broncho Pneumonia</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Arteriosclerotic C.V.D.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Terminal Broncho Pneumonia</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>423.1 II Bilat. Amputee</u>				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>May 21</u> 19 <u>64</u> to <u>Jan 30</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Jan 30</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.				
23A. SIGNATURE <u>William D. Appleford</u>			23B. DATE SIGNED <u>1/30/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>William D. Appleford M.D.</u>			23D. ADDRESS <u>6615 Reisterstown Rd</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>2/1/68.</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 31 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>



R-300 68-1239

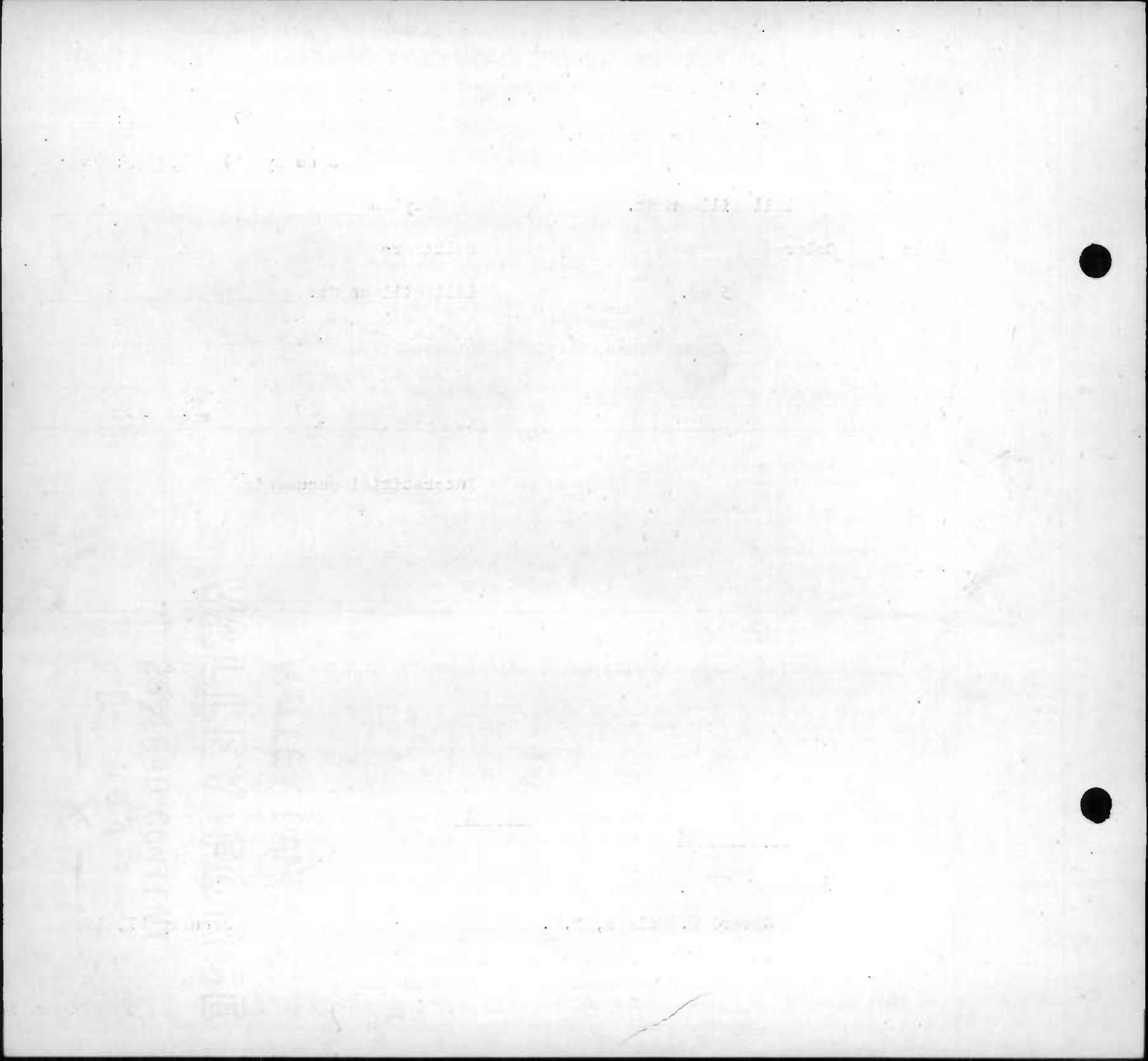
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-1239

BIRTH NO. 67-16273

1. NAME OF DECEASED (Type or Print) DESMOND L. REDD		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 27 68 5:00a M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 1311 Hillman St. (If not in hospital or institution, give street address or location)		3. DATE PRONOUNCED DEAD Month Day Year Hour January 27 1968 5:00a M.	
6. SEX Male		7. RACE Colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY	
9. DATE OF BIRTH		10. AGE (In years last birthday) 5 mo.	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Calvin Johnson		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby	
15. MOTHER'S MAIDEN NAME Karen Redd		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. —		18. INFORMANT Karen Redd	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 484 X I Interstitial pneumonia DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 525 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) YES		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes XX Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Edward F. Wilson EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED January 27, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-31-68	
24C. NAME OF CEMETERY or CREMATORY MT. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 31 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Chung O. Wilson		ADDRESS 1000 Bently Dr.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
M-200 68-1240		68-1240		68-1240	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
MCCOY, Lucille		1-31-68 4:49 PM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
Johns Hopkins Hospital		A. STATE B. COUNTY MAR VIRGINIA			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
Johns Hopkins Hospital		APPOMATTOX		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER		V-43	
		P.O. Box 262			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
F	C	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9-12-27	40	U S A
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Greensboro NC	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
JACK JONES		MARY GRAY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
m				Solomon D McCoy	
				ADDRESS	
				Same	
18. 400.0 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Malignant Hypertension			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
445 X II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
				No	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from January 20 1968 to January 21 1968, that (X) (we) last saw the deceased alive on January 21 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
John T. Flaherty				1/21/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
JOHN T. FLAHERTY				THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1-28-68		Morningside Cmt	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 31 1968		Robert E. Taylor		West & Bone Apportionment	
				ADDRESS	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1241	
BIRTH NO. 0-120		68-1241		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) April DAVIS		2. DATE AND HOUR OF DEATH 1/28/68-10:25 10:25P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland, B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital BALTIMORE, Maryland.		E. STREET AND NUMBER 2011 E. Jefferson St.			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/12/65	9. AGE (In years lost birthday) 2 YEARS	10. AGE (In years lost birthday) 2 YEARS
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10B. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) BALTIMORE	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles DAVIS			
14. MOTHER'S MAIDEN NAME BARBARA GOINES		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO.		17. INFORMANT Charles DAVIS			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Asphyxia House FIRE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. E916.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A) 19A. DATE OF OPERATION 1-25-68 2:13M 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home 21C. WHERE DID INJURY OCCUR? 2011 E. Jefferson St. 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 1-25-68 2:13M 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> 21F. HOW DID INJURY OCCUR? probably a faulty heater 22. I certify that (I) this hospital attended the deceased from 1/27 19 68 to 1/28 19 68, that (II) (we) last saw the deceased alive on 1/28 19 68 and that in my (aur) opinion death occurred on the date and hour and from the causes stated above. (II) (We) did (did not) view the body after death. 23A. SIGNATURE James B. Brayton M.D. 23B. DATE SIGNED 1/28/68 23C. PHYSICIAN'S NAME (Type) JAMES B. BRAYTON 23D. ADDRESS THE JOHNS HOPKINS HOSPITAL 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 1-30-68 24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cmt 24D. LOCATION (City, town, or county) (State) Baltimore Md 25A. DATE REC'D BY HEALTH DEPT. JAN 31 1968 25B. NAME OF REGISTRAR Robert E. Finkbeiner 25C. FUNERAL DIRECTOR Chas. Wilson 1000 Brumby St 25D. ADDRESS					

Baltimore Maryland

F. W.

n/a

via

Thurs. 22. Davis

no

all E. papers
all papers

Baltimore

Baltimore

all papers

all papers

all papers

all papers

all papers

all papers

James B. Smith

all papers

all papers

all papers

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-450		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1242	
68-1242		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) WILLIS BOYLIN		2. DATE AND HOUR OF DEATH 28 JANUARY 1968 8:20 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY		5. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224		E. STREET AND NUMBER 1205 Decker Avenue - 21213			
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/3/10	9. AGE (In years last birthday) 57	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Paul Wallace		14. MOTHER'S MAIDEN NAME WALLACE, Drucilla	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS: Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224	
18. 174X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 170X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Anemia, thrombocytopenia		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of Breast (B) Hemothorax DUE TO, OR AS A CONSEQUENCE OF: (C) Hypercalcemia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unknown 8 Days	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from JANUARY 14 19 68 to JANUARY 28 19 68 , that (we) last saw the deceased alive on JANUARY 28 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) (we) (did) (not) view the body after death.					
23A. SIGNATURE Michael R. McMillan		23B. DATE SIGNED 1/28/68		23C. PHYSICIAN'S NAME (Type) MICHAEL R. MCMILLAN	
23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Baltimore, Md. 21224		23E. FUNERAL DIRECTOR Brown & House Union & Co. Henry O. Wilson 1000 Bunting Ave.		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-4-68		24C. NAME OF CEMETERY or CREMATORY St Luke Baptist Church	
24D. LOCATION (City, town, or county) (State) South Carolina		24E. DATE REC'D BY HEALTH DEPT. JAN 31 1968		24F. NAME OF REGISTRAR Robert E. Johnson	

25 January 1968

25 January 1968

25 January 1968

25 January 1968

68-1243

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-1243

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

EUGENE KLUNK

2. DATE OF DEATH

Known ☒ Estimated ☐

Month

Day

Year

Hour

1

27

68

10:10 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33

Johns Hopkins Hospital

3. DATE PRONOUNCED DEAD

Month

Day

Year

Hour

January

27

1968

10:10 a.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

53-00

6. SEX

Male

7. RACE

White

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐NO ☒

9. DATE OF BIRTH

10 Aug 09

10. AGE (In years lost birthday)

58

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

Box 11 Route 15 Balto. County

11. BIRTHPLACE (State or foreign country)

Adams Co., Pa.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Joseph Klunk

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Mechanic

14B. KIND OF BUSINESS OR INDUSTRY

Construction

15. MOTHER'S MAIDEN NAME

Bernadine Shorb

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

205-07-0515

18. INFORMANT

ADDRESS

Cyril Klunk McSherrystown, Pa.

19. 412.01

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Intracerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF:

(B) Hypertensive Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

443X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Tunnel

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Harbor Tunnel thoroughway 5000 ft. S.

22D. TIME OF INJURY (APPROX.)

12 11 67 12:20

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject in auto-auto collision

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 28, 1968

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1-30-68

24C. NAME of CEMETERY or CREMATORY

Annunciation

24D. LOCATION (City, town, or county) (State)

McSherrystown, Adams, Pa.

25A. DATE REC'D BY HEALTH DEPT.

JAN 31 1968

25B. NAME OF REGISTRAR

Robert E. Wilson

25C. FUNERAL DIRECTOR

ADDRESS

Tipton - Elmer Funeral Home Hagerstown

THE
UNITED STATES
DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D. C. 20240

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
DATE: [illegible]

1. [illegible]
2. [illegible]
3. [illegible]
4. [illegible]
5. [illegible]
6. [illegible]
7. [illegible]
8. [illegible]
9. [illegible]
10. [illegible]

1. NAME OF DECEASED (Type or Print) JAMES B. THOMAS, Sr.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> January 28, 1968 9:50 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 N. MORLEY STREET (DOA)		3. DATE PRONOUNCED DEAD Month Day Year January 28, 1968 9:50 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 20-07	
9. DATE OF BIRTH JAN. 15 1900		10. AGE (In years last birthday) 68 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector City Sanitation		14B. KIND OF BUSINESS OR INDUSTRY City Sanitation	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 215-10-0843	
18. INFORMANT VERNA LEE		ADDRESS 16 CEDARNEKE Rd Owings Mills	
19. 412.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 422.31			
20A. DATE OF OPERATION 2-2-68		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) Month Day Year Hour 2-2-68		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) No	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-30-68			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 2-2-68	
24C. NAME OF CEMETERY or CREMATORY LONDON PARK		24D. LOCATION (City, town, or county) (State) BALTIMORE, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 31 1968		25B. NAME OF REGISTRAR Robert E. Feltner	
25C. FUNERAL DIRECTOR Geo. L. Schwab Funeral Home		ADDRESS Francis H. Spitz 2101 Redwood Ave.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1245
BIRTH NO. 68-1245		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Rev. John R. Bates		2. DATE AND HOUR OF DEATH 1.29.68 10.50 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY 16-02 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 904 N. Calhoun Street		
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9.12.06	9. AGE (In years last birthday) 61
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Columbia, S. C.
13. FATHER'S NAME Drake Bates		14. MOTHER'S MAIDEN NAME Maggie Mears		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-67-5799		17. INFORMANT Mrs. Laura Bates ADDRESS 904 N. Calhoun St
18. 572.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MASSIVE HEMORRHAGE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. EXTENSIVE DIVERTICULOSIS COLON		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 572.1 II				
19A. DATE OF OPERATION 1.15.68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED MASSIVE GI BLEEDING		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 1.15.68 to 1.29.68 , that (I) (we) last saw the deceased alive on 1.29.68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE R. Theodore		23B. DATE SIGNED 1.29.68		23C. PHYSICIAN'S NAME (Type) ROGER THEODORE
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 2-3-68		24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park
25A. DATE REC'D BY HEALTH DEPT. JAN 31 1968		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR Morton E. Dyett F.H. ADDRESS 1701 Laurens St

91206 61

Columbia 20

Madison House

Minister
Lake House

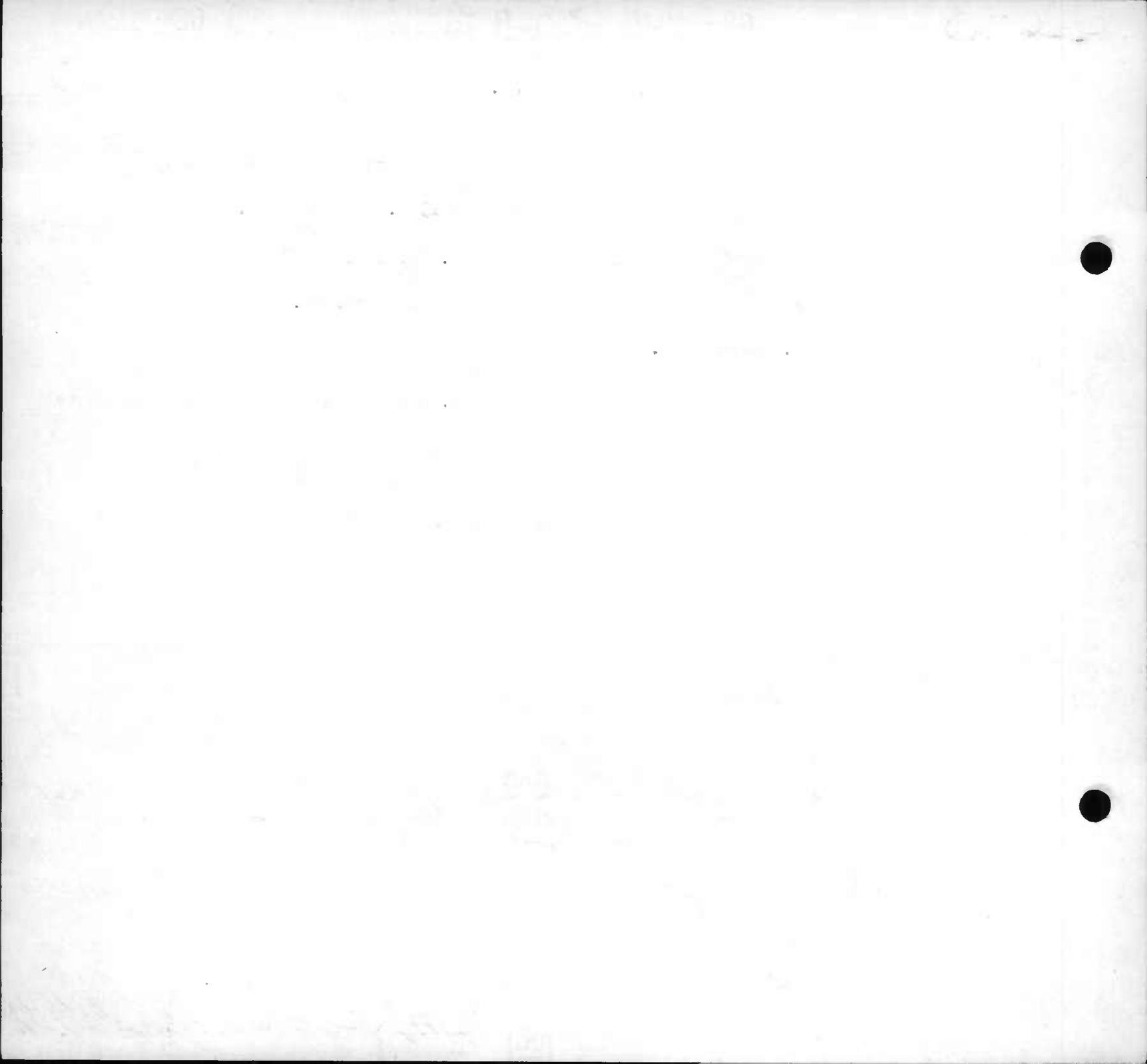
2-2-20 The house date

2-2-20 The house date
Minister 2-2-20

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 68- 1246	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 68- 1246 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) Thomas FREDERICK COARD Jr.			2. DATE AND HOUR OF DEATH 1/26/68 7:30 A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-18 D. STREET ADDRESS (If rural, give location) 3713 W. Garrison Ave.		
5. SEX M	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Sept. 24, 1911	9. AGE (In years last birthday) 56	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Frederick T. Coard Sr.			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Louise Coard same address as above	
18. 491X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Respiratory Insufficiency DUE TO (B) Emphysema and Chronic Bronchitis DUE TO (C) Smoking ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
18. 502.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/12/68 19 to 1/26 19 68 , that (I) (we) lost saw the deceased alive on 1/25/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Abe Levy				23B. DATE SIGNED 1/26/68/0800	
23C. PHYSICIAN'S NAME (Type) ABE LEVY				23D. ADDRESS Sinai Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/29/68		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Md.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. FEB 1 1968		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR WM J. Fickman & Sons	
25D. ADDRESS Baltimore					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1247

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68-1247

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Louise Polsey Kuhn

2. DATE AND HOUR OF DEATH

January 29, 1968 9:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Long Green Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐

NO ☐

E. STREET AND NUMBER

3401 N. Calvert St. 2128

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

July 19, 1885

9. AGE (In years
last birthday)

82

If Under 1 Yr. If Under 24 Hrs.

Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Boston, Mass.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

George Arlon Polsey

14. MOTHER'S MAIDEN NAME

Jennie Peterson

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL SECURITY NO.

212-09-5683 D

17. INFORMANT

Mr. Bradford Kuhn, Jr. 909 Whitney Dr. Aiken, S. C.

18. 43619 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

331X II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☒

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-29-68 to 1-29-68, that (I) (we) last saw the deceased alive on 1-29-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

William G. Helfrich, M.D.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

1-30-68

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

5006 Roland Avenue, 21210

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

1/31/68

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Crematory

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

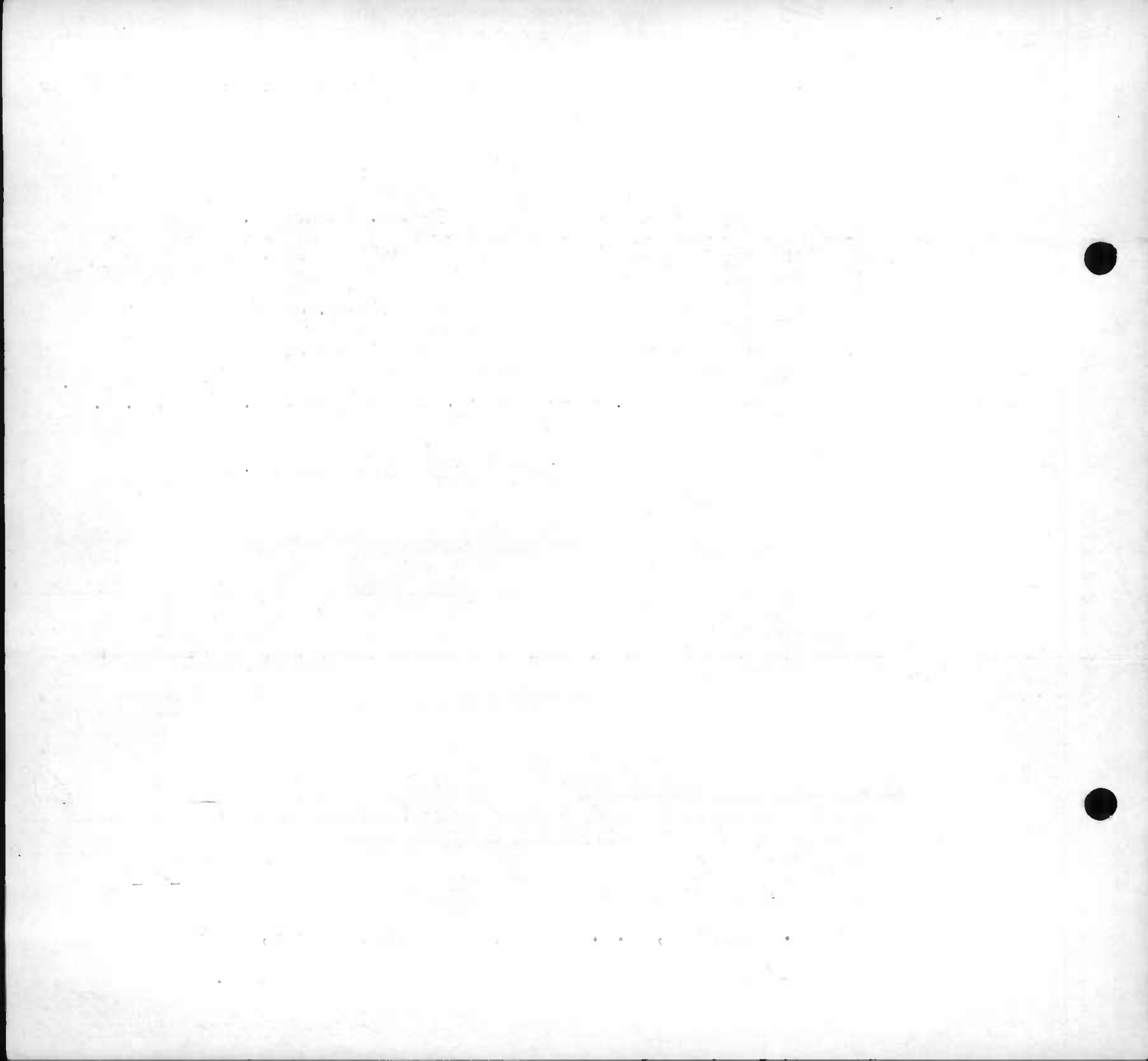
FEB 1 1968

25B. NAME OF REGISTRAR

Robert E. Faldut

25C. FUNERAL DIRECTOR

Wm J. Fickner & Sons Baltimore, Md.



Released by Medical Examiner on Approval

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1P-525 68-1248

BIRTH NO. 68-1248

CERTIFICATE OF DEATH

REG. NO. 68-1248

1. NAME OF DECEASED (Type or Print) University Hosp Pinkine, John Thomas

2. DATE AND HOUR OF DEATH 1-29-68 7:17 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD University Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD B. COUNTY Springfield ST Hosp. 56-00
C. CITY OR TOWN Sykesville Md. D. INSIDE CITY LIMITS ☐ YES ☐ NO
E. STREET AND NUMBER

5. SEX M 6. RACE W 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH 4/17/98 9. AGE (In years lost birthday) 69

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic - Retired 10B. KIND OF BUSINESS OR INDUSTRY Maryland 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? Maryland

13. FATHER'S NAME Frank M Pinkine 14. MOTHER'S MAIDEN NAME Margaret Dakis

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 216-09-4883 17. INFORMANT ADDRESS Mrs. Edna Grimes Pinkine Elkton, Md.

18. 410.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction 19. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) HASCD

20. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction (B) HASCD (C) Subtrochanteric Fracture, femur, right

21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate 7 years 2 mos.

22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II

23. MEDICAL CERTIFICATION (B) 1/24/68 24. CONDITION FOR WHICH OPERATION WAS PERFORMED Dry gangrene right leg 25. AUTOPSY? (Yes or No) Yes 26. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NOT AVAILABLE AT THIS TIME

27. 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐ 21B. PLACE OF INJURY (e.g., home, farm, factory, street, office bldg., etc.) Institution 21C. WHERE DID INJURY OCCUR? Springfield State Hospital, Sykesville, Md.

28. 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 11/27/67 4:30 PM 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☒ 21F. HOW DID INJURY OCCUR? Indeterminate

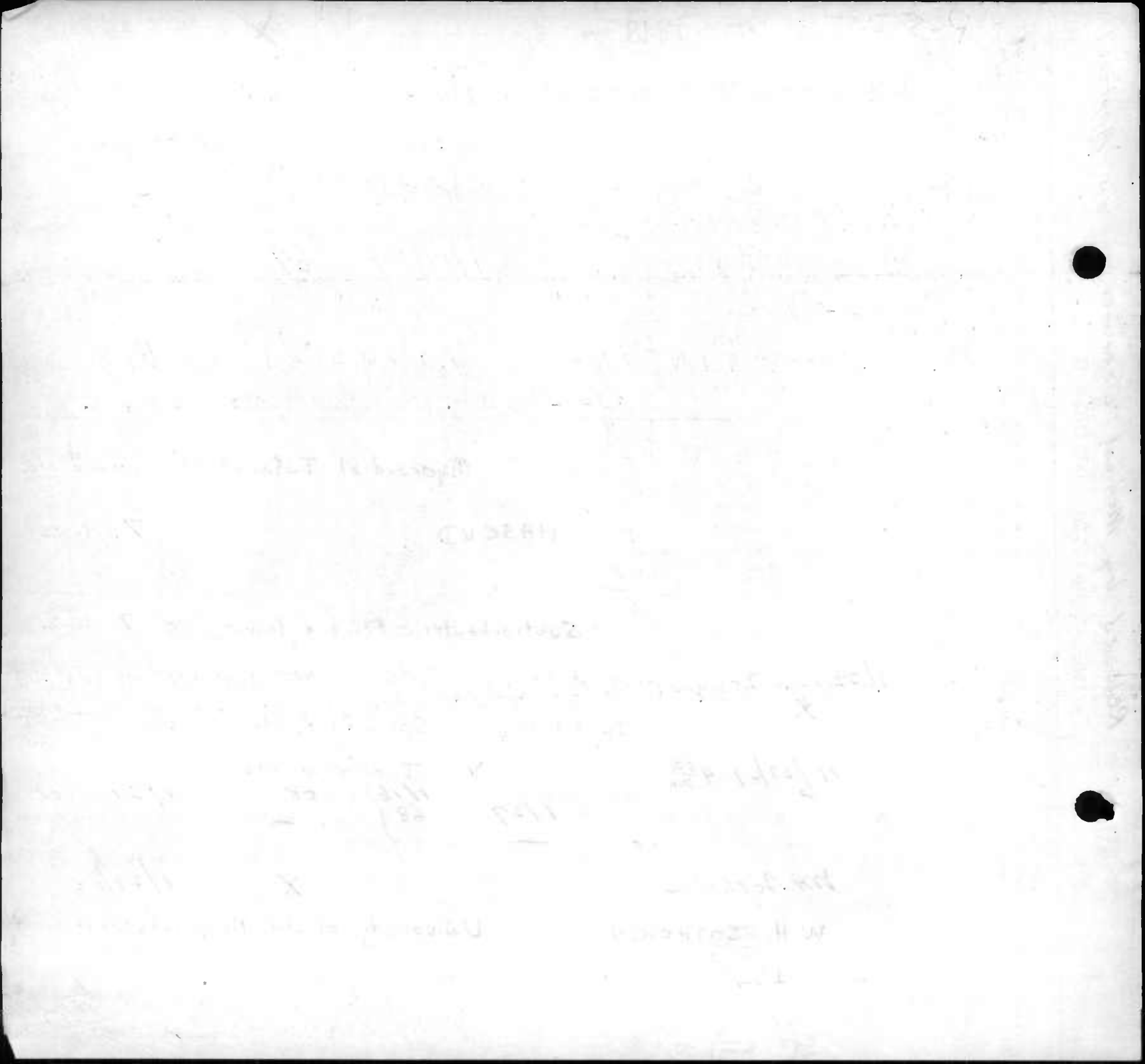
29. 22. I certify that (this hospital) attended the deceased from 1/16 1968 to 1/29 1968, that (we) last saw the deceased alive on 1/29 1968 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.

30. 23A. SIGNATURE W.H. SOTHORON 23B. DATE SIGNED 1/29/68

31. 23C. PHYSICIAN'S NAME (Type) W.H. SOTHORON 23D. ADDRESS University of Md. Hospital, Baltimore, Md.

32. 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 1/31/68 24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery 24D. LOCATION (City, town, or county) (State) Baltimore, Md.

33. 25A. DATE REC'D BY HEALTH DEPT. FEB 1 1968 25B. NAME OF REGISTRAR Robert E. Fairbank 25C. FUNERAL DIRECTOR ADDRESS Wm J. Tichman & Sons Baltimore, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 68-1249	
BIRTH NO. 68-1249		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WOOLFORD, GEORGE WALTER		2. DATE AND HOUR OF DEATH JAN. 30, 1968 9:15 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY		5. CITY OR TOWN (If outside city limits, give rural, and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL		6. STREET ADDRESS (If rural, give location) 715 STAMFORD ROAD		7. CITY OR TOWN 21229	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 08-05-94	9. AGE (In years last birthday) 73	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME HARRISON A. Woolford		14. MOTHER'S MAIDEN NAME AMELIA STEINBOCK		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 213 10 7665		17. INFORMANT ADDRESS CATON & WILKENS AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Heart Failure (B) Myocardial Infarction (C)		INTERVAL BETWEEN ONSET AND DEATH Progressive 2 Mo.	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION 4-20-1		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED II	
20A. AUTOPSY (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JAN. 22 1968 to JAN. 30 1968, that (I) (we) last saw the deceased alive on JAN. 30 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE (Signature) M.D.		23B. DATE SIGNED 1-30-68			
23C. PHYSICIAN'S NAME (Type) Raymond D. BARR M.D.		23D. ADDRESS CATON & WILKENS AVE. BALTIMORE MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/2/68		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. DATE REC'D BY HEALTH DEPT. FEB 1 1968		24F. NAME OF REGISTRAR Robert E. Farkner	
24G. DATE REC'D BY HEALTH DEPT. FEB 1 1968		24H. NAME OF REGISTRAR Robert E. Farkner		24I. FUNERAL DIRECTOR William Farkner	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-1250</u>
BIRTH NO. <u>68-01327</u> <u>1275897</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Robinson James H. JR</u>		2. DATE AND HOUR OF DEATH <u>1-29-68</u> <u>8:30</u> <u>4</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 Johns Hopkins Hosp</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE CITY</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
		E. STREET AND NUMBER <u>2241 EAST PRESTON STREET</u> <u>21213</u>		
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-21-68</u>	9. AGE (In years lost birthday) <u>8</u> days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>JAMES H. Mc Robinson SR.</u>		14. MOTHER'S MAIDEN NAME <u>Deborah Robinson</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>—</u> ADDRESS <u>—</u>	
18. <u>776.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>IMMATUREITY</u> DUE TO, OR AS A CONSEQUENCE OF: <u>IDIOPATHIC RESPIRATORY DISTRESS SYNDROME</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>PULMONARY HEMORRHAGE</u> (C) <u>—</u>		
19. DATE OF OPERATION <u>2</u>		20A. AUTOPSY? (Yes or No) <u>yes</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>		
22. I certify that (I) (the hospital) attended the deceased from <u>1-21-68</u> 19 to <u>1-29-68</u> 19, that (I) (we) last saw the deceased alive on <u>1-29-68</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above <u>(I) (We) did</u> (did not) view the body after death.				
23A. SIGNATURE <u>Robert Suskind MD</u>		23B. DATE SIGNED <u>1-29-68</u>		23C. PHYSICIAN'S NAME (Type) <u>Robert Suskind MD</u>
23D. ADDRESS <u>John Hopkins Hosp</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u>		
24B. DATE <u>1-29-68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Johns Hopkins Hosp</u>		
24D. LOCATION (City, town, or county) <u>BALTIMORE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>FEB 1 1968</u>		
25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>		25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u>		

1-21-68

Baltimore

Deborah Robinson

JAMES H.
Mr. Robinson Sr.

NO

yes

1-22-68

○ ○

Robert Robinson

Robert Robinson

Robert Robinson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-1251</u>
S-160		68-1251		CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>HARRY SCHAPIRO</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>JANUARY 30, 1968</u> <u>1</u> <u>P.</u> M.		
FULL NAME OF HOSPITAL OR INSTITUTION <u>1503 DESOTO ROAD</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1503 DESOTO ROAD #21230</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 15, 1903</u>	9. AGE (In years last birthday) <u>64</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRODUCE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>LOUIS SCHAPIRO</u>		
14. MOTHER'S MAIDEN NAME <u>REBECCA ULMAN</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. DOROTHY SCHAPIRO, 1503 DESOTO RD. #21230</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>154, 14-280.9</u> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma Rectum</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Diabetes Mellitus</u> (C) <u>154X II</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>2 years</u>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 1967</u> to <u>Jan 1968</u> , that (I) (we) lost saw the deceased alive on <u>JAN 28 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Paul Schonfeld</u>		23B. DATE SIGNED <u>1/30/68</u>		23C. PHYSICIAN'S NAME (Type) <u>PAUL SCHONFELD</u>
23D. ADDRESS <u>2301 ANNAPOLIS ROAD BALTIMORE 30 Md</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		
24B. DATE <u>1-31-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>NESNIA</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 1 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Indye</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-1252
BIRTH NO. 1		68-1252		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <div style="text-align: center;">ROSE COHEN</div>			2. DATE AND HOUR OF DEATH <div style="text-align: center;">JANUARY 30, 1968</div> 12:30 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <div style="text-align: center;">MARYLAND</div> B. COUNTY <div style="text-align: center;">BALTIMORE</div>		
FULL NAME OF HOSPITAL OR INSTITUTION <div style="text-align: center;">BELVEDERE NURSING HOME, HOUSE IN THE PINES</div>			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="text-align: center;">HOUSEWIFE</div>			11. BIRTHPLACE (State or foreign country) <div style="text-align: center;">BALTIMORE, MARYLAND</div>		
10B. KIND OF BUSINESS OR INDUSTRY <div style="text-align: center;">AT HOME</div>			12. CITIZEN OF WHAT COUNTRY? <div style="text-align: center;">U.S.A.</div>		
13. FATHER'S NAME <div style="text-align: center;">ISAAC FELDMAN</div>			14. MOTHER'S MAIDEN NAME <div style="text-align: center;">VETTA ?</div>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <div style="text-align: center;">NO</div>			16. SOCIAL SECURITY NO.		
17. INFORMANT <div style="text-align: center;">MRS. VETTA CLUSTER, APT. 103</div>			ADDRESS <div style="text-align: center;">7938 DUNHILL VILLAGE CIRCLE #21207</div>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <div style="text-align: center;">467.1 II</div>			CAUSE OF DEATH <div style="text-align: center;">Hereditary Hemorrhagic Telangiectasia 5 yrs.</div>		
19. DATE OF OPERATION			20A. AUTOPSY? (Yes or No)		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
22. I certify that (I) (this hospital) attended the deceased from <div style="text-align: center;">June 1967</div> to <div style="text-align: center;">Jan 1968</div> , that (I) (we) last saw the deceased alive on <div style="text-align: center;">Jan 28 1968</div> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <div style="text-align: center;">Samuel V. Tompakov</div>			23B. DATE SIGNED <div style="text-align: center;">Jan 30, 1968</div>		
23C. PHYSICIAN'S NAME (Type) <div style="text-align: center;">SAMUEL V. TOMPAKOV</div>			23D. ADDRESS <div style="text-align: center;">3600 PARK HEIGHTS AVENUE</div>		
24A. BURIAL CREMATION, REMOVAL (Specify) <div style="text-align: center;">BURIAL</div>			24B. DATE <div style="text-align: center;">2-1-68</div>		
24C. NAME OF CEMETERY or CREMATORY <div style="text-align: center;">BNAI ISRAEL</div>			24D. LOCATION (City, town, or county) (State) <div style="text-align: center;">BALTIMORE, MARYLAND</div>		
25A. DATE REC'D BY HEALTH DEPT. <div style="text-align: center;">FEB 1 1968</div>			25B. NAME OF REGISTRAR <div style="text-align: center;">Robert S. Feldman</div>		
25C. FUNERAL DIRECTOR <div style="text-align: center;">SOL LEVINSON & BROS., 6010 REISTERSTOWN RD.</div>			ADDRESS		

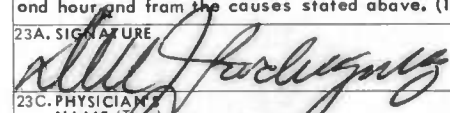
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1253

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-1253

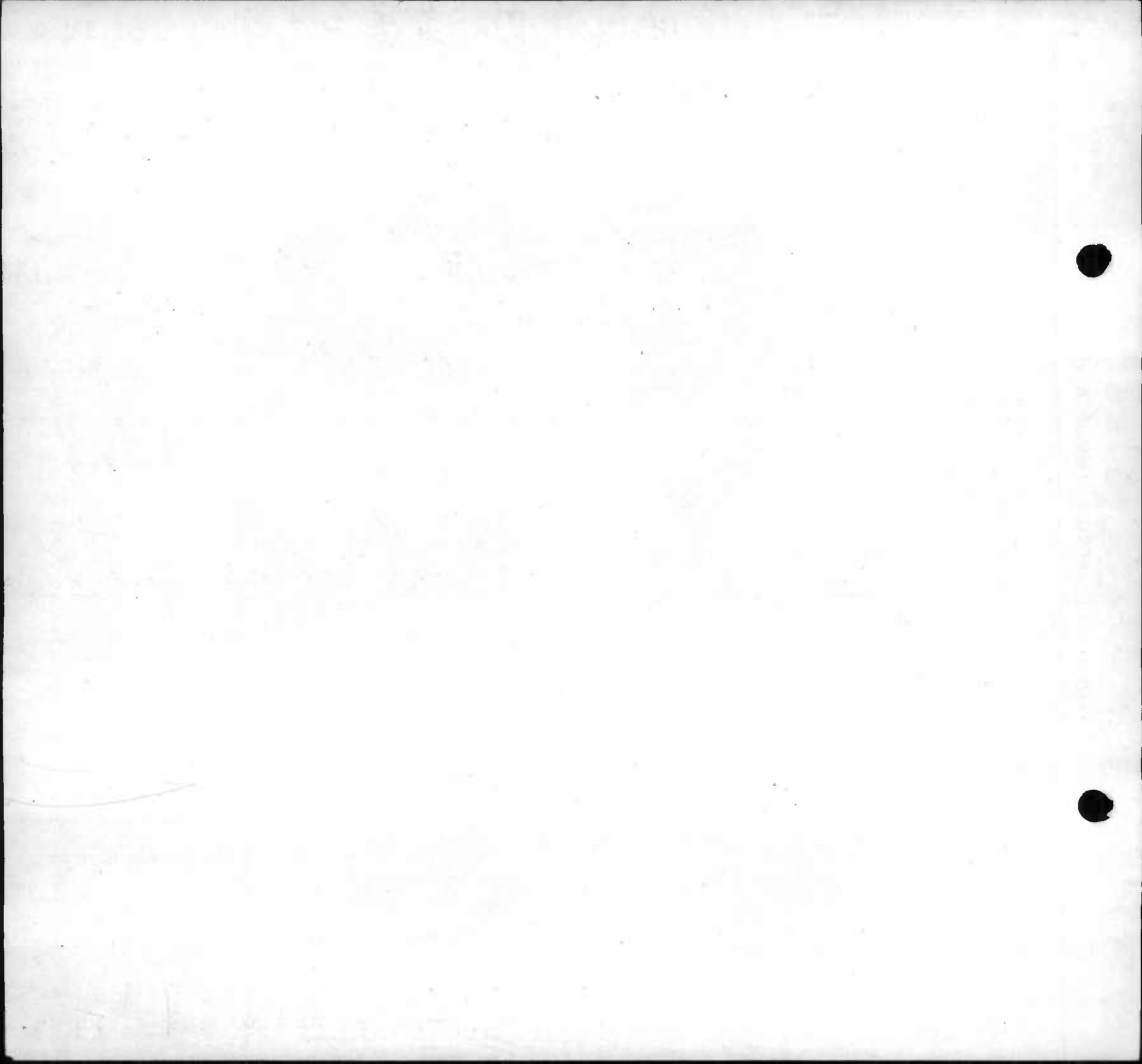
BIRTH NO.		1. NAME OF DECEASED (Type or Print) WHALEN, Julia M. (Miss)		2. DATE AND HOUR OF DEATH Jan. 30, 1968 2:10 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION JENKINS MEMORIAL HOSPITAL 1000 S. Caton Ave. Balto., Md. 21229			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore 21223 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1042 W Lombard St.		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-24-1892	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSE		10B. KIND OF BUSINESS OR INDUSTRY NURSING		11. BIRTHPLACE (State or foreign country) Baltimore.	
13. FATHER'S NAME Andrew M. Whalen			14. MOTHER'S MAIDEN NAME Mary French		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-54-0072		17. INFORMANT ADDRESS Medical Records Rm= Jenkins Memorial	
18. 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 331 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: BILATERAL PNEUMONIA (B) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF: Gen. arteriosclerosis (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks several yrs. 2 11
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1966 to Jan. 1968 , that (I) (we) last saw the deceased alive on 1-29-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  23C. PHYSICIAN'S NAME (Type) Manuel de J. Rodriguez				23B. DATE SIGNED 1-30-68	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/2/68		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.	
24D. LOCATION (City, town, or county) (State) 4300 Old Frederick Rd. Md.		25A. DATE REC'D BY HEALTH DEPT. FEB 1 1968			
25B. NAME OF REGISTRAR Robert E. F. [Signature]		25C. FUNERAL DIRECTOR ADDRESS John H. [Signature] 9012 Hollister St. 23, Md.			

W. J. Harrison

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1254		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 1254	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Robert H. Rice Jr.		2. DATE AND HOUR OF DEATH 1-29-68	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 15-11			
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3414 Copley Rd.					
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-23-12	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POSTMAN		10B. KIND OF BUSINESS OR INDUSTRY U.S. Post Office		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Robert Rice Sr.		14. MOTHER'S MAIDEN NAME Amy Mary Tripp		12. CITIZEN OF WHAT COUNTRY? U.S.A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WWII		16. SOCIAL SECURITY NO. 216053539		17. INFORMANT Vivian Rice same wife	
18. 5-21-0-1 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Shock ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. G.I. Bleeding LASANGE'S Cirrhosis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs 48 hrs YEARS	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 581.1 II					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-2 19 68 to 1-29 19 68 , that (I) (we) last saw the deceased alive on 1-29 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
23A. SIGNATURE Michael Kaliner MD				23B. DATE SIGNED 1/29/68	
23C. PHYSICIAN'S NAME (Type) Michael Kaliner MD				23D. ADDRESS University Hospital-Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-2-68		24C. NAME OF CEMETERY OR CREMATORY Balto. Nat'l. Cem.	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR Kelson Funeral Home 1348 Calhoun St.		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1255	
<div style="display: flex; justify-content: space-between;"> W-3162 68-1255 CERTIFICATE OF DEATH </div>					
BIRTH NO. <u>THOMAS WATERS</u>			1. NAME OF DECEASED (Type or Print) <u>Thomas Walter Waters</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			2. DATE AND HOUR OF DEATH <u>1-30-68</u> <u>6</u> <u>A.M.</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Lincoln Nursing Home</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>19-03</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>10 S. Calhoun St</u>					
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-29-1873</u>	9. AGE (In years last birthday) <u>94</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>musician</u>			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <u>VA. Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Unknown Jefferson Waters</u>			14. MOTHER'S MAIDEN NAME <u>Unknown Ellen Dawson</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>220-14-0308A</u>		
17. INFORMANT <u>Mrs. Katie E. Kelly</u>			ADDRESS <u>10 S. Calhoun St.</u>		
18. <u>188X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CARCINOMA of Bladder</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
18. <u>1810</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>11-13</u> 19 <u>67</u> to <u>1-30</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1-30-</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Thomas J. Kennison</u>			23B. DATE SIGNED <u>1-30-68</u>		
23C. PHYSICIAN'S NAME (Type) <u>Thomas J. Kennison</u>			23D. ADDRESS <u>5519 Kennison Av Baltimore, Md</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>2/2/68</u>		
24C. NAME OF CEMETERY OR CREMATORY <u>Mount Hebron Cemetery</u>			24D. LOCATION (City, town, or county) (State) <u>Winchester, Virginia</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 1 1968</u>			25B. NAME OF REGISTRAR <u>Robert E. Fairbank</u>		
25C. FUNERAL DIRECTOR <u>Walters Funeral Home</u>			ADDRESS <u>Pratt & Stricker Sts.</u>		

12-11-1911

11-11

11-11

11-11-1911

11-11-1911

11-11-1911

68-1256 CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

PLATON KREDICH

2. DATE AND HOUR OF DEATH

Jan 30, 1968 2:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)35 CHURCH HOME AND
HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

207 HERRING CT.

5. SEX

M

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

1-30-87

9. AGE (In years
last birthday)

81

If Under 1 Yr.

If Under 24 Hrs.

Months Days

Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

STEADORE

10B. KIND OF BUSINESS OR INDUSTRY

U.S. FRUIT CO.

11. BIRTHPLACE (State or foreign country)

RUSSIA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218-01-6768

17. INFORMANT

HARRIS ANDROSIK

ADDRESS

137 S CENTRAL
AVE.

18.

4129 I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

1-29-68

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED

strangulated sig. tumor

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 27 1968 to January 30 1968
that (I) (we) last saw the deceased alive on January 30 1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Jose S. Maisog

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

1-30-68

23C. PHYSICIAN'S
NAME (Type)

Jose S. Maisog

DEGREE

23D. ADDRESS

Chand Amel Day

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

2-2-68

24C. NAME OF CEMETERY or CREMATORY

Holy Trinity Russian Cem.

24D. LOCATION

(City, town, or county)

(State)

Elbridge, Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

FEB 1 1968

P. C. & P. F. J. J. J.

W. Fialkowski 2007 Eastern Ave.

21231

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1874
257
12

Alfred
1874
257

Alfred
1874
257

Alfred
1874
257

Alfred
1874
257

Alfred
1874
257

Alfred
1874
257

127 36 75
GREENWAY, RALPH B.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 650				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1257	
1. NAME OF DECEASED (Type at Print) GREENWAY, Ralph B				2. DATE AND HOUR OF DEATH 1.30.68 5⁴⁰ A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 33 The Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE Virginia B. COUNTY Arlington			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 The Johns Hopkins Hospital				C. CITY OR TOWN Arlington		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 500 - 26th St., South				V-43			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-25-11	9. AGE (In years last birthday) 56	If Under 1 Yr. Months: 0 Days: 5	If Under 24 Hrs. Hours: 5 Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Safety Instructor U.S. Government..				10B. KIND OF BUSINESS OR INDUSTRY Pentagon Building		11. BIRTHPLACE (State or foreign country) HOT SPRINGS, ARKANSAS	
12. CITIZEN OF WHAT COUNTRY? UNITED STATES				13. FATHER'S NAME Charles O. Greenway			
14. MOTHER'S MAIDEN NAME Lydia M. Barnett				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT (Wife) MRS. DOROTHY GREENWAY ADDRESS ARLINGTON, VIRGINIA 500 A.S. 26th ST			
18. 011.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory arrest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonitis, tuberculosis (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 min 6 mo.							
19. 492X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Possible myocardial infarction							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1.6.68 to 1-30.68 and that (we) last saw the deceased alive on 1.30.68 and that in (my) (our) opinion death occurred on the date 1-30.68 and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Christopher B. Merritt						23B. DATE SIGNED 1.30.68	
23C. PHYSICIAN'S NAME (Type) Christopher B. Merritt, M.D.						23D. ADDRESS Johns Hopkins Hospital, Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1/2/1968		24C. NAME OF CEMETERY OR CREMATORY BURIAL 1		24D. LOCATION (City, town, or county) (State) HOT SPRINGS, ARKANSAS	
25A. DATE REC'D BY HEALTH DEPT. FEB 1 1968		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR MARTIN W. HYSONG COMPANY-1300 N. ST., N. WASH. D. C.			

(Responsible B. Moore, MD)
Chapman B. Moore

1.50

1.50

1.50

1.50

1.50

Chapman B. Moore, MD

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1258

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-1258

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

THERESA M. SHEARER

2. DATE AND HOUR OF DEATH

1/30/68 2³⁰ A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

48 MARYLAND GENERAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND Baltimore 53-00

C. CITY OR TOWN Reisterstown

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

201 Glynndon Drive

5. SEX

6. RACE

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

9. AGE (In years last birthday)

10. Under 1 Yr. 11. Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Basil Carey

14. MOTHER'S MAIDEN NAME

Margaret Redmond

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

495-30-0778

17. INFORMANT

EDGAR SHEARER

ADDRESS

Reis. Md., 229 Glynndon

18.

412.9 I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

Cerebral Vascular Thrombosis days

(B) DUE TO, OR AS A CONSEQUENCE OF:

ASCVD years

(C) DUE TO, OR AS A CONSEQUENCE OF:

420.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

Coronary artery disease years

19A. DATE OF OPERATION

None

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

None

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Justify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ☒ (this hospital) attended the deceased from 1/19 1968 to 1/30 1968, that ☒ (we) lost saw the deceased alive on 1/29 1968 and that in (my) ☒ opinion death occurred on the date and hour and from the causes stated above. (I) ☒ (did) ☒ view the body after death.

23A. SIGNATURE

C. S. R. R. R.

OEGREE

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

1/30/68

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

OEGREE

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Feb. 2, 1968 New Cathedral Cen.

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

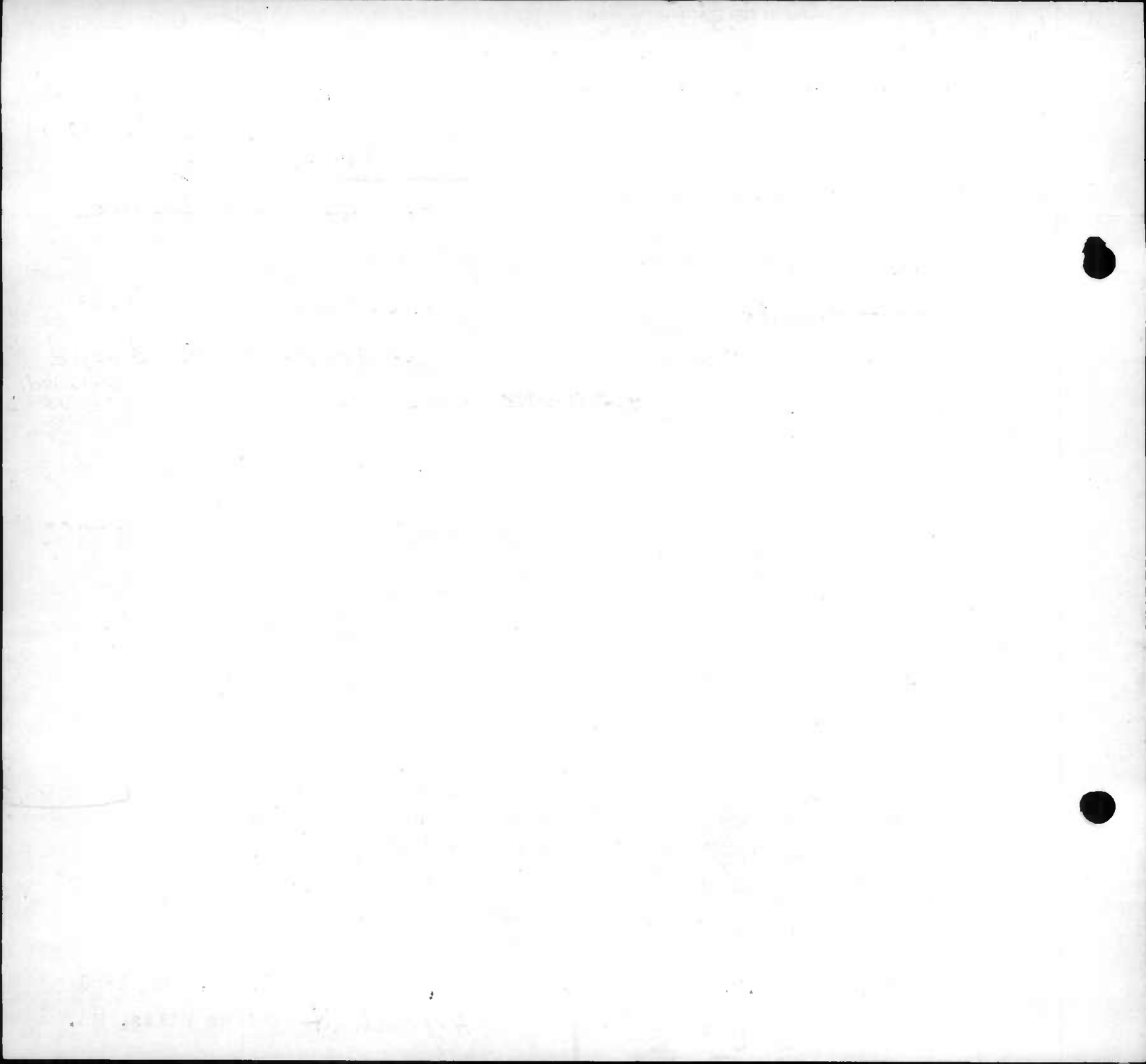
25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

FEB 1 1968 Robert E. Jankowski

H. J. Schhardt Owings Mills, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1259

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 1259

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

DAVID H GROOMS

2. DATE AND HOUR OF DEATH

1-28-68 10 55 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

MD 4002 EIERMAN AVE

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

4002 EIERMAN AVE.

5. SEX

Male

6. RACE

White

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

12-14-16

9. AGE (In years last birthday)

51

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Painter

10B. KIND OF BUSINESS OR INDUSTRY

Balto. City

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Thomas Grooms

14. MOTHER'S MAIDEN NAME

Bertha Norris

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)
Yes

WWII

16. SOCIAL SECURITY NO.

218-05-5139

17. INFORMANT

Mary B. Grooms-4002 Eierman Ave.

ADDRESS

18. CAUSE OF DEATH

410.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

MYOCARDIAL INFARCTION 20 MIN

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

420.1 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from SEPT 1 1967 to 1-28 1968, that (I) (we) last saw the deceased alive on 1-25-68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S NAME (Type)

FRANCIS X CARNEY

DEGREE

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

23D. ADDRESS

3201 S. CHARLES ST

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1-31-68

24C. NAME OF CEMETERY or CREMATORY

Baltimore National Cemetery

24D. LOCATION

Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.

SEB 1 1968

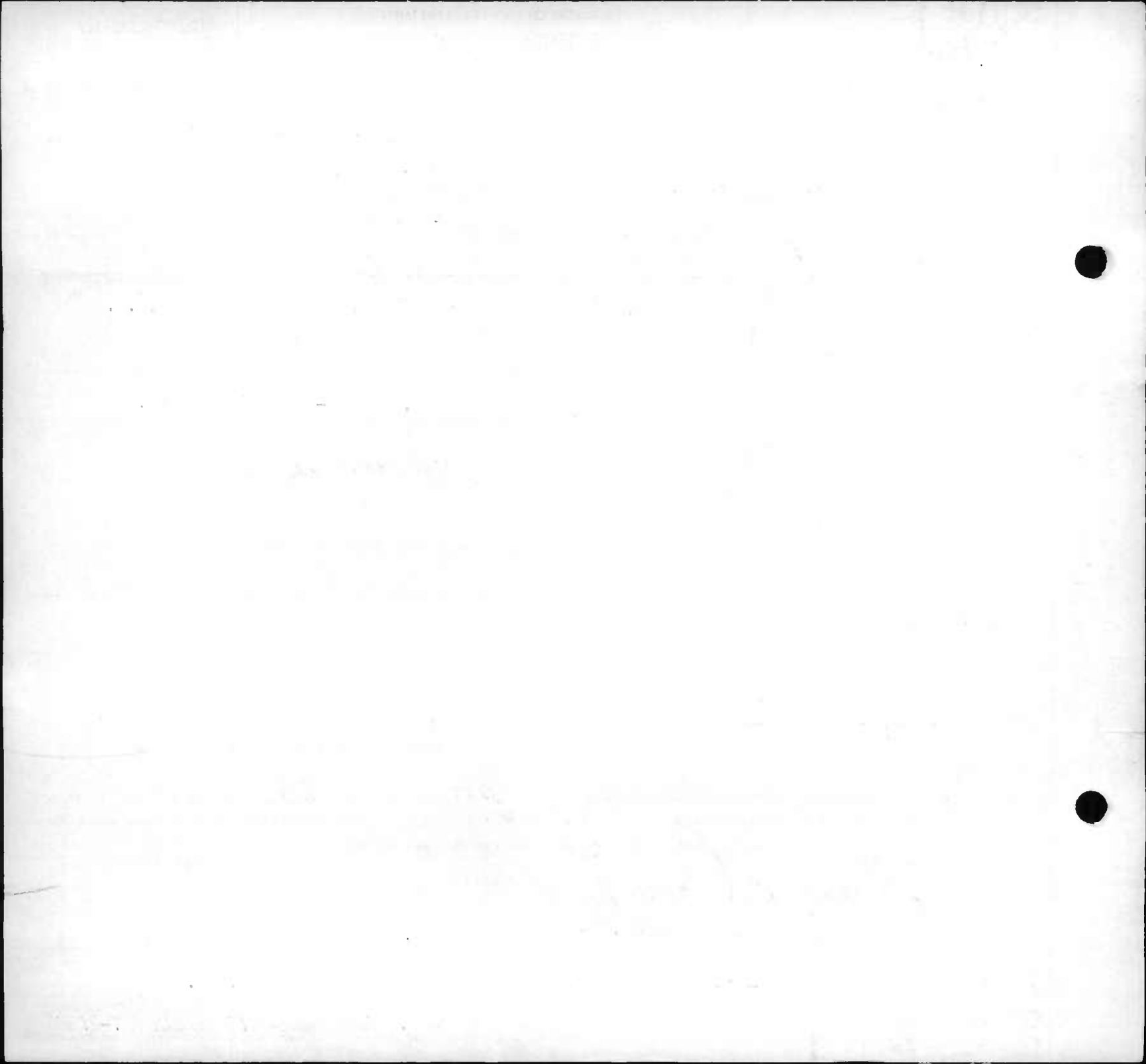
25B. NAME OF REGISTRAR

John E. Fairbank

25C. FUNERAL DIRECTOR

John C. Miller Inc-6415 Belair Rd.-21206

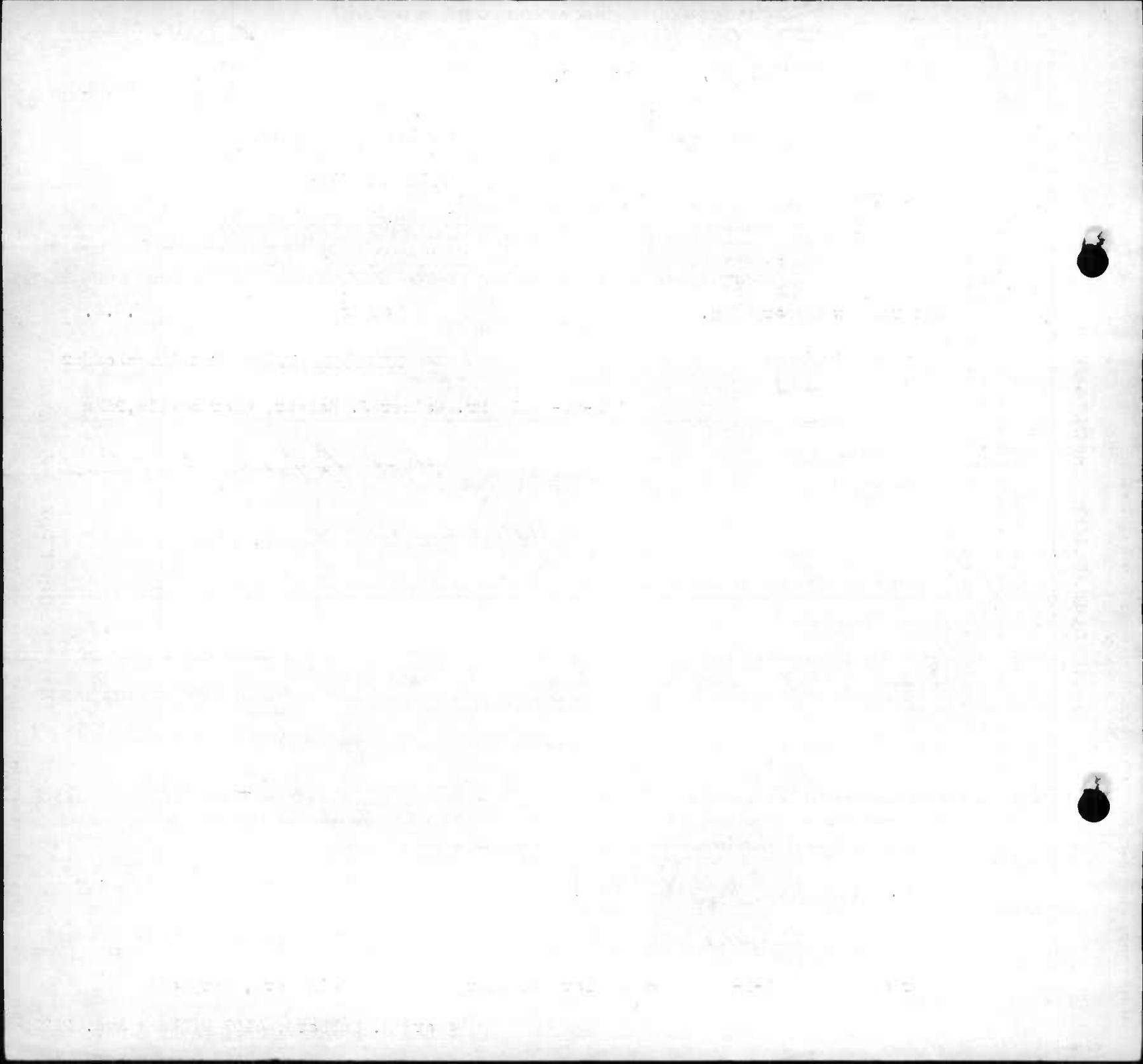
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-1260</u>
BIRTH NO. <u>2-260</u>		68-1260 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>ZAISER, Leonard G.</u>		2. DATE AND HOUR OF DEATH <u>1-31-68</u> <u>8:15 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>The Johns Hopkins Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Howard</u> C. CITY OR TOWN <u>Ellicott City</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>Clarksville Pike RFD 4</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/10/01</u>	9. AGE (In years last birthday) <u>66</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Stationary Eng.</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Herman Zaiser</u>		
14. MOTHER'S MAIDEN NAME <u>Anna Rothlingshoffer</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>215-09-6817</u>		17. INFORMANT ADDRESS <u>Mr. Walter J. Zaiser, Clarksville Pike</u>		
18. <u>154, I</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Metastatic Ca of Rectum</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. DATE OF OPERATION <u>Dec 1, 1967</u>		20. AUTOPSY? (Yes or No) <u>NO</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>1-3</u> <u>1968</u> to <u>1-31</u> <u>1968</u> , that (I) (we) last saw the deceased alive on <u>1-31</u> <u>1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Antonio Gonzalez</u>		23B. DATE SIGNED <u>1-31-68</u>		
23C. PHYSICIAN'S NAME (Type) <u>Antonio Gonzalez - M.D.</u>		23D. ADDRESS <u>Johns Hopkins Hosp. Balto Md.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>2-3-68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>FEB 1 1968</u>		
25B. NAME OF REGISTRAR <u>Robert E. Farkner</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>		



S-431

68- 1261

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 1261

BIRTH NO.		1. NAME OF DECEASED (Type or Print) PEARL B. SELTZER		2. DATE AND HOUR OF DEATH 1-28-68 8 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		5. CITY OR TOWN FREE LAND D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205		E. STREET AND NUMBER Mt. Carmel Rd.			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-12-83	9. AGE (In years last birthday) 84	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME RUBEN LENTZ		14. MOTHER'S MAIDEN NAME Mary Hunt	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 179-20-8339A		17. INFORMANT HUSBAND WILLIAM SELTZER ADDRESS FREE LAND, MD.	
18. 412.94-250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diabetes mellitus		CAUSE OF DEATH Arteriosclerotic Heart Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 years	
19A. DATE OF OPERATION 1-28-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Bilateral femoral occlusion		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input type="checkbox"/>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from 1-28-68 to 1-28-68 and that (I) (we) lost saw the deceased alive on 1-28-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Benjamin Lechner, M.D.				23B. DATE SIGNED 1/28/68	
23C. PHYSICIAN'S NAME (Type) BENJAMIN LECHNER		23D. ADDRESS JHH			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/31/68		24C. NAME OF CEMETERY or CREMATORY Middletown Cem.	
24D. LOCATION (City, town, or county) (State) Freeland, Md.		25A. DATE REC'D BY HEALTH/DEPT. FEB 1 1968			
25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR'S ADDRESS Jacob Hartenstein, New Freedom, Pa.			

NO

FUNERAL DIRECTOR: IMPORTANT

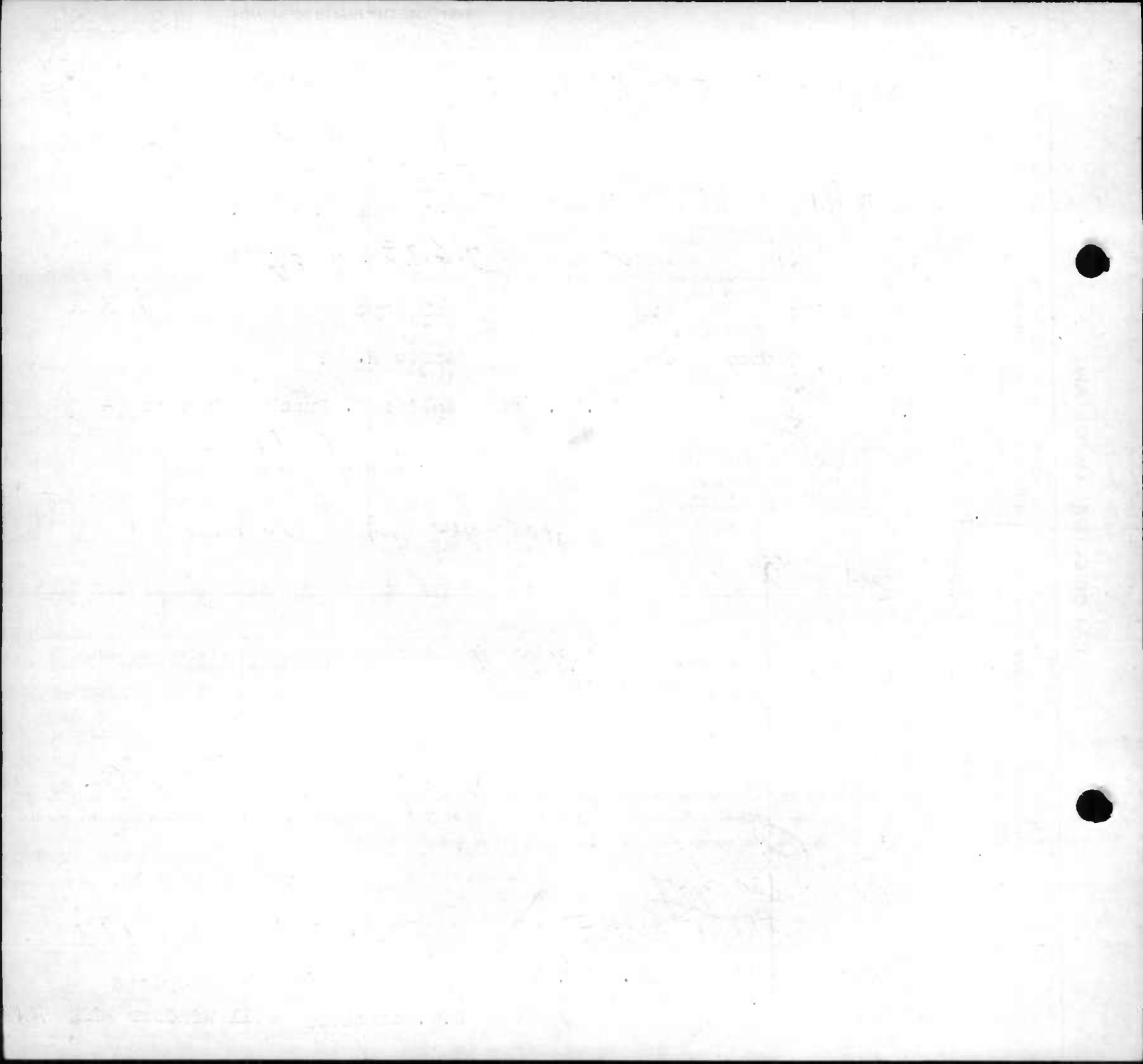
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-1262 CERTIFICATE OF DEATH

REG. NO.

68-1262

BIRTH NO.		1. NAME OF DECEASED MARGARET BURKOWSKIE		2. DATE AND HOUR OF DEATH 1. 30.68	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD SINAI HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Balt		5. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 5807 Gwynn Oak Ave.		6. DATE OF BIRTH 7.6.83		7. AGE (In years last birthday) 84	
8. SEX F	9. RACE W	10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME ? Tucker		14. MOTHER'S MAIDEN NAME Annie E. ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NO	
16. SOCIAL SECURITY NO. 213.18.6008		17. INFORMANT Julius H. Busch		ADDRESS Same as #4	
18. 570.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Intestinal obstruction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Volvulus Small Intestine		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Intestinal obstruction (B) Volvulus Small Intestine (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. 570.3 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 1. 25.68		20. AUTOPSY? (Yes or No) 1. 25.68		21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
22. I certify that (I) (this hospital) attended the deceased from 1. 25.68 to 1. 30.68 and that (I) (we) first saw the deceased alive on 1. 30.68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23. SIGNATURE J. T. Stahsbury		24. DATE SIGNED 1. 30.68	
25. PHYSICIAN'S NAME (Type) ROBERT E. JOHNSON		26. ADDRESS SINAI HOSPITAL		27. DATE SIGNED 1. 30.68	
28. BURIAL CREMATION, REMOVAL (Specify) Burial		29. DATE 2/2/68		30. NAME OF CEMETERY OR CREMATORY Mt. Olivet	
31. LOCATION Baltimore Maryland		32. DATE REC'D BY HEALTH DEPT. FEB 1 1968		33. NAME OF REGISTRAR Robert E. Johnson	
34. FUNERAL DIRECTOR J. T. Stahsbury		35. ADDRESS 6411 Windsor Mill Rd.		36. DATE SIGNED 1. 30.68	



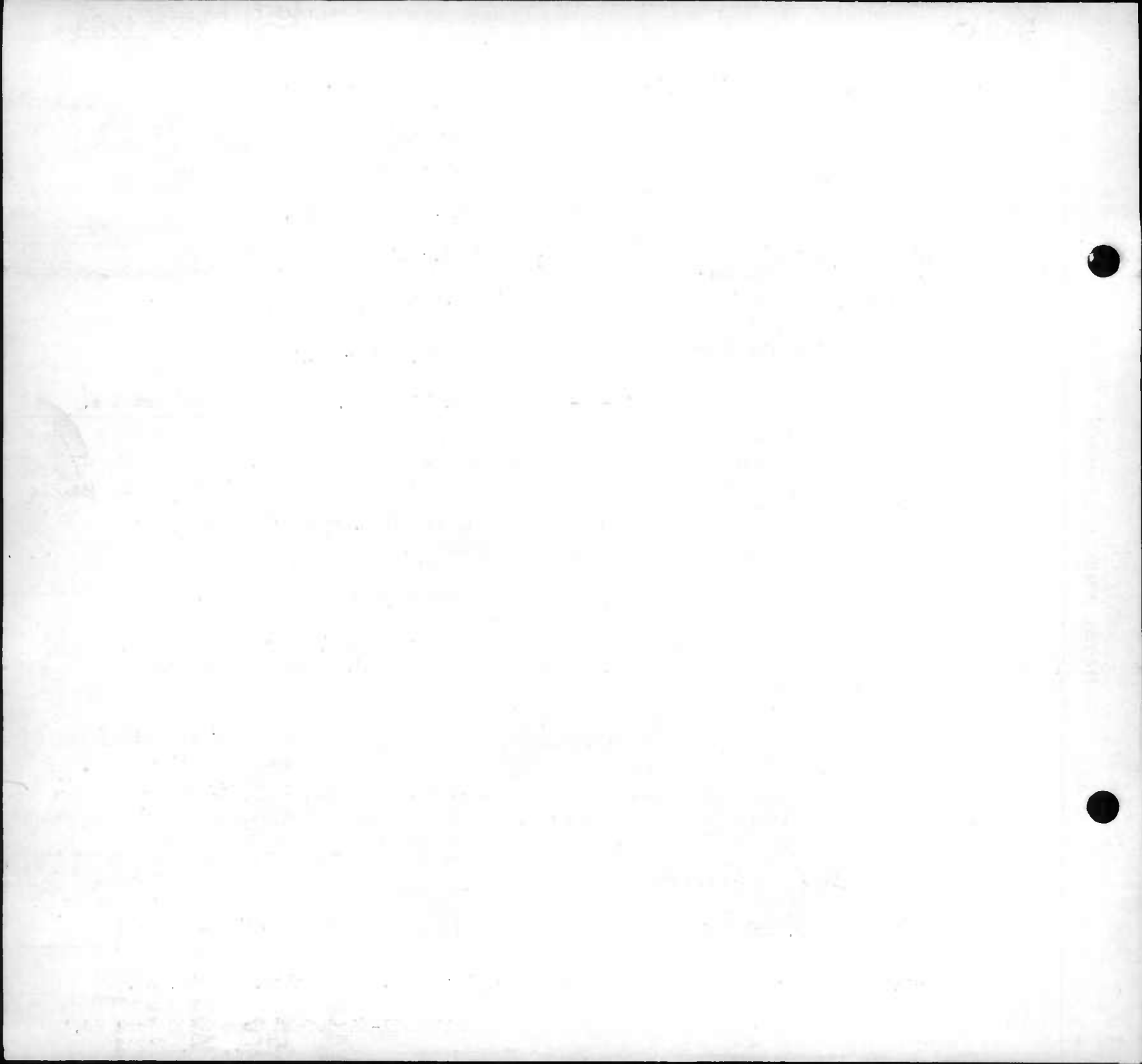
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

68- 1263 CERTIFICATE OF DEATH

REG. NO. 68- 1263

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		William Henry Campbell Hyde		Jan. 27, 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 5664 Woodmont Ave.				A. STATE Maryland	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 5664 Woodmont Ave.	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
male	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Sept. 26, 1878	89	USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
machinist				Baltimore, Maryland	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Francis Hyde			USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
no			218-03- 7437		Mrs. Lillie J. Hyde 5664 Woodmont Ave.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES				with Cerebral Thrombosis	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:	
				(C) DUE TO, OR AS A CONSEQUENCE OF:	
332X II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				2 months	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/27/68 to 1/27/68 that (I) (we) last saw the deceased alive on 1/26/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Sol Smith M.D.				23B. DATE SIGNED 1/29/68	
23C. PHYSICIAN'S NAME (Type) Dr. Sol Smith				23D. ADDRESS 1267 E. Belvedere Ave	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
burial		1/30/68		Moreland Memorial Grds.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
FEB 1 1968		Robert E. Taylor		Mitchell-Wiedefeld Home 6500 York Rd., Balto., Md. 21212	

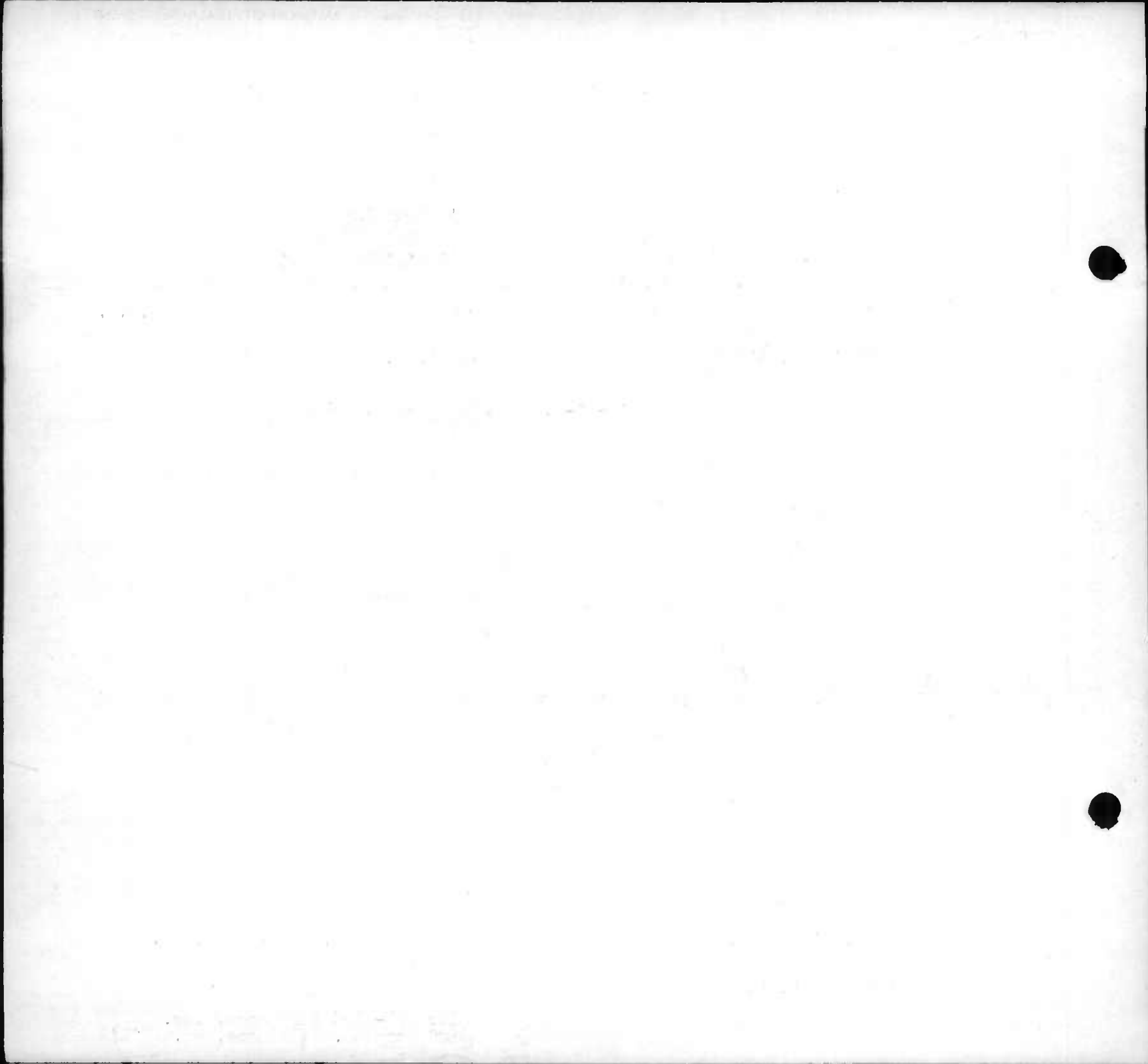


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 1264 CERTIFICATE OF DEATH

REG. NO. 68- 1264

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		PEARLA LITSINGER COLES		JANUARY 28, 1968 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
00 4618 Schenley Road				Maryland	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				4618 Schenley Road	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	April 21, 1876 91		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)	
Housewife		Home		11. BIRTHPLACE (State or foreign country)	
				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
William D. Litsinger		Amelia C. Hawkins		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		217-01-9936 B		Miss Leah N. Coles Same	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Vascular Accident 10 days					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:					
331X II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1956 to 1968, that (I) (we) last saw the deceased alive on 1-28-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Dr. William G. Helfrich				1-30-68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. William G. Helfrich				5006 Roland Ave. Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1-31-68		Loudon Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
FEB 1 1968		Robert E. Farkas		Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212	



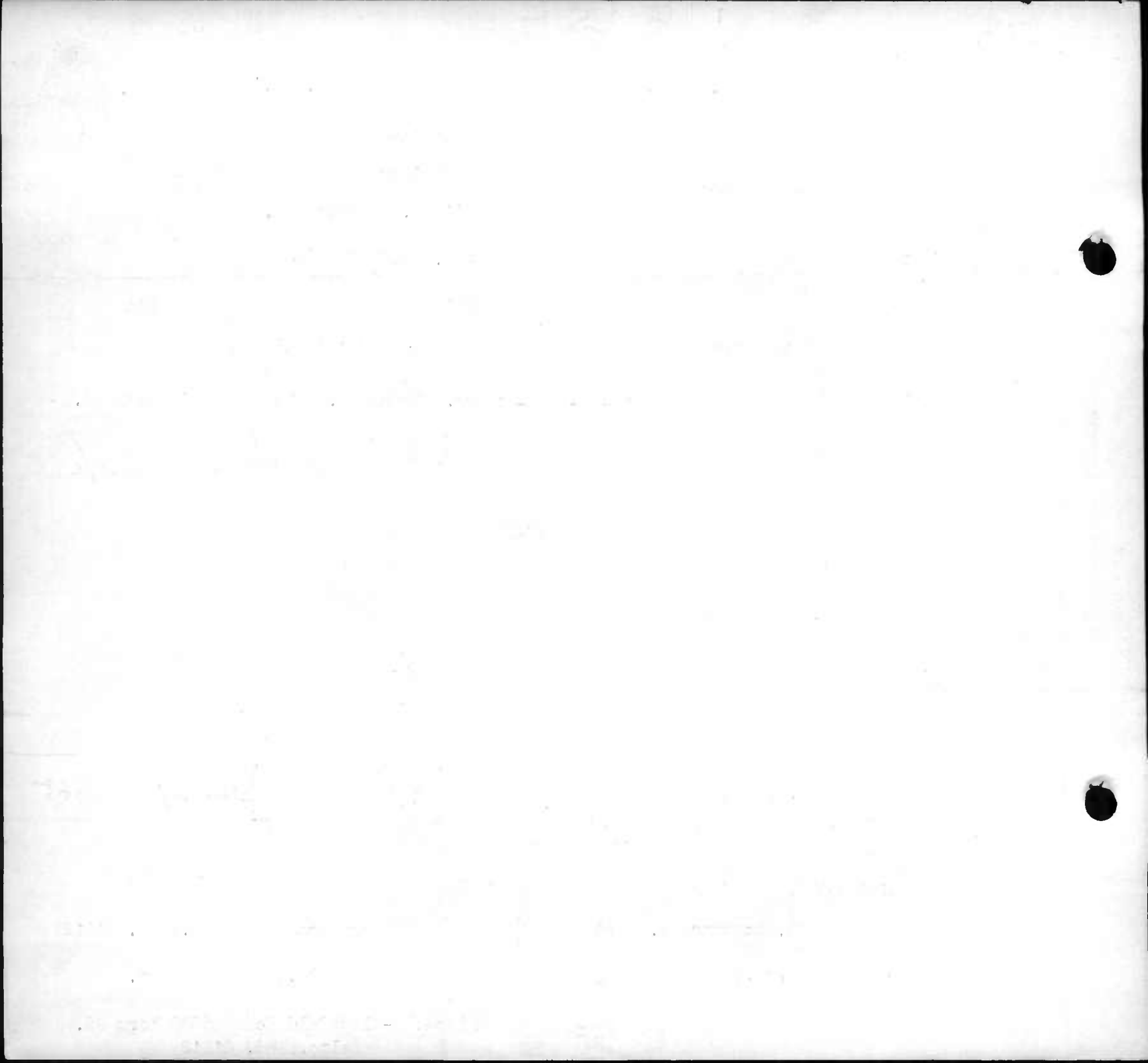
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

68- 1265 CERTIFICATE OF DEATH

REG. NO. 68- 1265

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Anna J. Kluge		Jan. 29, 1968 4.45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
90 Long Green Nursing Home				Maryland	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				115 E. Melrose Ave.	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)
female	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Aug. 23, 1883		84
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
none					Germany
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?
Herman Kluge			Schniert Franciska Shiner		USA
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		215-54-1279-J1		Mrs. Stephen G. Moran 809 Kingston Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES				Cerebral Hemorrhage	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Arteriosclerosis	
				(C)	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
331 X II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 2/17/67 to Jan. 29 1968, that (I) (we) last saw the deceased alive on Jan. 29 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Dr. Lawrence C. Post				1/30/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Lawrence C. Post				6805 York Road Balto., Md. 21212	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		1/31/68		Loudon Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
FEB 1 1968		Robert E. Farkner		Mitchell-Wiedefeld Home 6500 York Rd, Balto., Md. 21212	

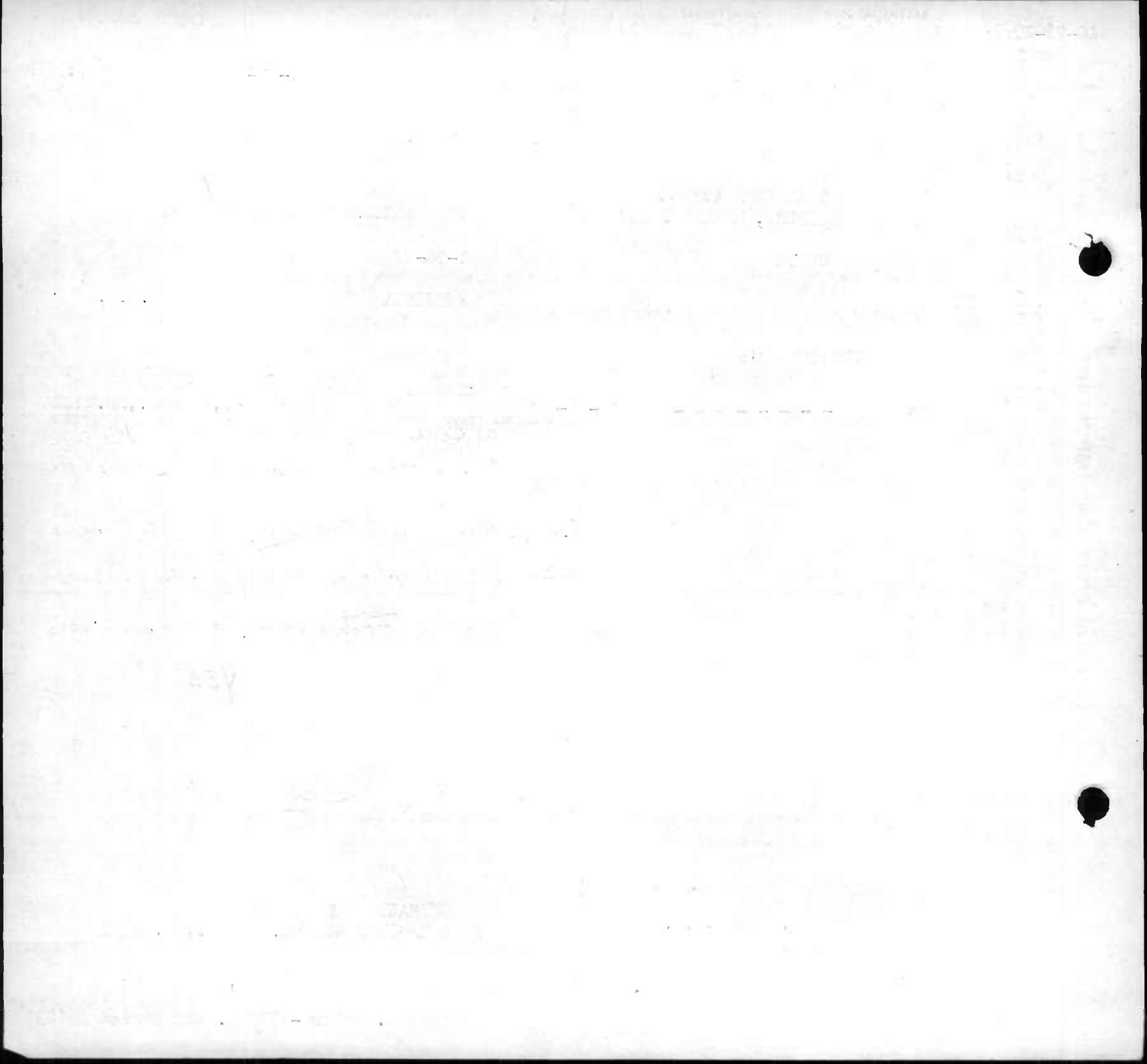


40-76-29 1B

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
BIRTH NO.				68-1266	
1. NAME OF DECEASED (Type or Print) <i>John V. Kuta</i>		JOHN KUTA		2. DATE AND HOUR OF DEATH <i>11-30-68</i> 7:35 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>31 BALTIMORE CITY HOSPITALS</i> <i>4940 EASTERN AVENUE</i> <i>BALTIMORE, MARYLAND 21224</i>		A. STATE MARYLAND		B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <i>1906 ALICEANN STREET # 21231</i>			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-18-07</i>	9. AGE (In years last birthday) <i>61</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Cemetery Maintenance</i>		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME <i>Vincent Kuta</i>			
14. MOTHER'S MAIDEN NAME <i>Theresa ?</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. <i>217-03-6572</i>		17. INFORMANT ADDRESS RECORDS: BALTIMORE CITY HOSPITALS 4940 EASTERN AVE., BALTO., MD. 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>410.9+1571.0</i>		CAUSE OF DEATH a) <i>Acute Myocardial Infarct</i> b) <i>Unproven Pulmonary Embolus - minutes</i> c) <i>Congestive Heart Failure</i> <i>ASCVD? Alcoholic Cardiomyopathy? years</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>420.1 II</i>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>RML pneumonia, Inactive Tbc, Laevecis Cirrhosis</i>			
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) YES	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11/13</i> 19 <i>68</i> to <i>11/30</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11/30</i> 19 <i>68</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>John R. Sharp MD</i>				23B. DATE SIGNED <i>11/30/68</i>	
23C. PHYSICIAN'S NAME (Typed) JOHN R. SHARP, M.D.				23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE., BALTO., MD. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE <i>2/2/68</i>		24C. NAME of CEMETERY or CREMATORY <i>St. Stanislaus Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>FEB 1 1968</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor, MD</i>		25C. FUNERAL DIRECTOR ADDRESS <i>George A. Weber - 705 S. Ann Street #21231</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1267

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-1267

BIRTH NO.		1. NAME OF DECEASED (Type or Print) FLORENCE B. PARKER		2. DATE AND HOUR OF DEATH 1/28/68 4 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY 9-09		5. CITY OR TOWN BALTO.	
FULL NAME OF HOSPITAL OR INSTITUTION 1413 E. FEDERAL ST		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F	6. RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/10/93	9. AGE (In years lost birthday) 74	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S. C.	
13. FATHER'S NAME Ostend Westbury		14. MOTHER'S MAIDEN NAME MARY		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Gus Williams 1402 E. MONUMENT ST	
18. 412.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Uremia		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Uremia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Oct. 67	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Chr. Nephritis		(B) DUE TO, OR AS A CONSEQUENCE OF: 1960		1951	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 443X II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1941 to Jan 28 1968 , that (I) (we) lost soul the deceased olive on Jan 19 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 1.31.68	
23C. PHYSICIAN'S NAME (Type) RAYNE BROWN, M. D. 1500 EAST MADISON ST. BALTIMORE, MD 21205					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 2/1/68		24C. NAME OF CEMETERY or CREMATION MT. CALVARY	
25A. DATE REC'D BY HEALTH DEPT. FEB 1 1968		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Joseph J. Lock 1304 K. Center St	

0001 214.0000 0000
(12) 0000.0000 0000

1041

P1 = 5/6

PI-106
1
11-10-10
11-10-10
11-10-10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				68-1268		68-1268	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Mary Hitzelberger</u>				2. DATE AND HOUR OF DEATH <u>Jan 30, 1968</u> <u>8:50p</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Church Home, Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>F-03</u>			
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>2539 E. Biddle St</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 12 1888</u>		9. AGE (In years last birthday) <u>79</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Unemployed</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Julius Rupp</u>				14. MOTHER'S MAIDEN NAME <u>Catherine — Neubert</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>212-48-8705-T</u>		17. INFORMANT <u>Steven V. Hitzelberger</u> ADDRESS <u>8600-9th Ave, Baltimore, Md.</u>	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>420.1 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Myocardial Infarction</u> (B) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>January 13 1968</u> to <u>January 30 1968</u> , that (I) (we) last saw the deceased alive on <u>January 30 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Rodelio M. Lim</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1-30-68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Rodelio M. Lim</u>				23D. ADDRESS <u>OHH</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb 3/68</u>		<u>Meadowridge mem Ph</u>		<u>Elkridge Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 1 1968</u>		25B. NAME OF REGISTRAR <u>R. E. F. F.</u>		25C. FUNERAL DIRECTOR <u>Philip Newig Sons</u>		ADDRESS <u>2624 Callicott St</u>	

201 13 13 13

California

California

201 13 13 13

California

California

California

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-320		68-1269		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1269	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) RIDDICK WILLIAM A.			
2. DATE AND HOUR OF DEATH 1/31/68 12.15 A.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 15-09				5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTIMORE			
6. CITY OR TOWN BALTIMORE				7. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
8. STREET AND NUMBER 2112 CHELSEA TERRACE				9. SEX MALE			
10. RACE Colored				11. MARIED <input checked="" type="checkbox"/> NEVER MARIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
12. DATE OF BIRTH SEPT 7, 1900				13. AGE (In years last birthday) 67			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard				15. KIND OF BUSINESS OR INDUSTRY Municipal Museum			
16. BIRTHPLACE (State or foreign country) BALTIMORE, Md				17. CITIZEN OF WHAT COUNTRY? U.S.A.			
18. FATHER'S NAME William A. Riddick				19. MOTHER'S MAIDEN NAME ANNIE TATUM			
20. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				21. SOCIAL SECURITY NO. 215-12-3636			
22. INFORMANT MRS. Altonia Riddick				23. ADDRESS 2112 Chelsea Terr			
24. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 410.9 I CARDIAC ARREST				25. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. MYOCARDIAL INFARCTION WITH VENTRICULAR FIBRILLATION			
26. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 420.1 II LARGE BOWEL PERFORATION PERITONITIS				27. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
28. DATE OF OPERATION 1/30/68				29. CONDITION FOR WHICH OPERATION WAS PERFORMED ILEUS			
30. AUTOPSY? (Yes or No)				31. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
32. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				33. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
34. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				35. HOW DID INJURY OCCUR?			
36. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				37. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
38. I certify that (I) (this hospital) attended the deceased from 1/14/68 to 1/31/68 , that (I) (we) last saw the deceased alive on 1/31/68 and that in (my) (our) opinion death occurred on the date 1/31/68 and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				39. DATE SIGNED 1/31/68			
40. SIGNATURE RKGrown				41. DATE SIGNED 1/31/68			
42. PHYSICIAN'S NAME (Type) PANAYIOTIS K SPANOS M.D.				43. ADDRESS SINAI HOSPITAL OF BALTIMORE			
44. BURIAL CREMATION, REMOVAL (Specify) BURIAL				45. DATE 2/5/68			
46. NAME OF CEMETERY OR CREMATORY New Cathedral Cem				47. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND			
48. DATE REC'D BY HEALTH DEPT. FEB 1 1968				49. NAME OF REGISTRAR Robert E. Farley			
50. FUNERAL DIRECTOR HERBERT E. NUTTEN				51. ADDRESS 3035 W. North Ave			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-1270</u>	
W-635		68-1270		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Priscilla Jane Worthington</u>			2. DATE AND HOUR OF DEATH <u>January 26, 1968</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>1005 W. Mulberry Street</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1005 W. Mulberry Street</u>		
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 30, 1929</u>	9. AGE (In years last birthday) <u>38</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Beautician</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	11. BIRTHPLACE (State or foreign country) <u>Nanticoke, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>James Waters</u>			14. MOTHER'S MAIDEN NAME <u>Leadella Carter</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>Mrs. Glendola Allain 5620 Arch Street Phila, Penna.</u>		
18. <u>410.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>420.1 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary Occlusion Sudden</u> (B) <u>Myocardial Failure</u> 14K.? (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>No</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)	(Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>Nov-25, 1967</u> to <u>Jan 26, 1968</u> , that (I) was last saw the deceased alive on <u>Nov-26, 1967</u> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) view the body after death.					
23A. SIGNATURE <u>Maurice L. Adams M.D.</u> DEGREE			23B. DATE SIGNED <u>1-29-68</u>		
23C. PHYSICIAN'S NAME (Type) <u>Maurice L. Adams</u>			23D. ADDRESS <u>238 N. Carey Street</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>2/1/68</u>	24C. NAME OF CEMETERY or CREMATORY <u>Nanticoke Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Nanticoke Maryland</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 1 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>	25C. FUNERAL DIRECTOR ADDRESS <u>Herbert E. Nutter 3035 W. North Ave.</u>		

1000 ft. - 1000 ft.

1000 ft. - 1000 ft.

1000 ft. - 1000 ft.

1000 ft. - 1000 ft.

1000 ft. - 1000 ft.

1000 ft. - 1000 ft.

1000 ft. - 1000 ft.

1000 ft. - 1000 ft.

1000 ft. - 1000 ft.

1000 ft. - 1000 ft.

1000 ft. - 1000 ft.

1000 ft. - 1000 ft.

1000 ft. - 1000 ft.

1000 ft. - 1000 ft.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-400		68-1271		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		68-1271	
CERTIFICATE OF DEATH									
BIRTH NO.		1. NAME OF DECEASED (Type or Print) CULLEY NANNIE				2. DATE AND HOUR OF DEATH 1-30-68 3 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 15-48				
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL					C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					E. STREET AND NUMBER 2208 GARRISON Blvd 21216				
5. SEX Female	6. RACE Cobred	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-11-03	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC			10B. KIND OF BUSINESS OR INDUSTRY PRIVATE FAMILY		11. BIRTHPLACE (State or foreign country) VIRGINIA (Richmond)		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME GEORGE WHITE				14. MOTHER'S MAIDEN NAME MARY ELIZABETH BALL					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 217-30-3547		17. INFORMANT Mr. Elvin White			
18. 486X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury at complication which caused death.) Pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Bilateral				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 days.			
19. 490X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1-21-68 19 to 1-30-68 19, that (I) (we) lost saw the deceased alive on 1-30-68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE J. Rafael					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) E. RAFAEL					23D. ADDRESS Lutheran Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Feb 4, 1968		24C. NAME OF CEMETERY OR CREMATORY Family Lot		24D. LOCATION (City, town, or county) (State) HANOVER County, Virginia			
25A. DATE REC'D BY HEALTH DEPT. FEB 1 1968			25B. NAME OF REGISTRAR Robert E. Jackson			25C. FUNERAL DIRECTOR HERBERT E. NUTTEN			
ADDRESS 3035 W. North Ave									



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 68- 1272	
BIRTH NO. 68- 1272		CERTIFICATE OF DEATH			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) POWELL William Henry		2. DATE AND HOUR OF DEATH 1-31-68 9.20 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3502 Holmes Ave. 17			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 2-16-69	9. AGE (In years lost birthday) 98	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10B. KIND OF BUSINESS OR INDUSTRY SELF Employed		11. BIRTHPLACE (State or foreign country) Howard Co, Md	
12. CITIZEN OF WHAT COUNTRY? U.S.A					
13. FATHER'S NAME ROBERT POWELL		14. MOTHER'S MAIDEN NAME JULIA PRETTYMAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-14-7693		17. INFORMANT ADDRESS MRS. Mary J. Hayes 3502 Holmes Ave	
18. 4379 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) cerebrovascular accident (B) 2 weeks (C) cerebral and generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH			
19. 331X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Severe dehydration					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-27-68 to 1-31-1968 , that (I) (we) last saw the deceased alive on 1-31-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. J. J. J.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> HO		23B. DATE SIGNED 1-31-68	
23C. PHYSICIAN'S NAME (Type) FRANCISCO SAENZ		23D. ADDRESS SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE FEB 3, 1968		24C. NAME OF CEMETERY or CREMATORY FAMILY LOT	
24D. LOCATION (City, town, or county) (State) DAISY, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. FEB 1 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS HERBERT E. NUTTEN 3035 W. North Ave	

1-10-2

2-10-2

3-10-2

4-10-2

5-10-2

6-10-2

7-10-2

8-10-2

9-10-2

10-10-2

11-10-2

12-10-2

13-10-2

14-10-2

15-10-2

16-10-2

17-10-2

18-10-2

19-10-2

20-10-2

21-10-2

22-10-2

23-10-2

24-10-2

25-10-2

26-10-2

27-10-2

28-10-2

29-10-2

30-10-2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-- 1273	
BIRTH NO. 5-532				68- 1273 CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Emil Santacrose - Saintcross			2. DATE AND HOUR OF DEATH Jan. 31, 1968 8:20 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) House in the Pines Bel Aire 5837 Belair Road 21 206			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 232 S. Conkling Street		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/16/92	9. AGE (In years last birthday) 75	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer - Retired			10B. KIND OF BUSINESS OR INDUSTRY Retired		
11. BIRTHPLACE (State or foreign country) Italy			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Pasquale Santacrose			14. MOTHER'S MAIDEN NAME Theresa		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.I National Guard			16. SOCIAL SECURITY NO. 217-05-5199		
17. INFORMANT Mrs. Anna Saintcross			ADDRESS 232 S. Conkling St		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Septicemia			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4-5 days		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Urinary Retention - catheter			(B) DUE TO, OR AS A CONSEQUENCE OF: Indwelling		
(C) DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of Prostate Gland 6 mos. +					
177X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Severe Coronary & peripheral arteriosclerosis					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-29-67 to 31 Jan 1968 , that (I) (we) last saw the deceased alive on 25 Jan 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE August D. King Jr. M.D.				23B. DATE SIGNED 1 Feb 68	
23C. PHYSICIAN'S NAME (Type) August D. King Jr. M.D.				23D. ADDRESS 1202 St. Paul St. Balto. Md 21202	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/3/68		24C. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery	
24D. LOCATION Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. FEB 1 1968		25B. NAME OF REGISTRAR Robert E. Tarkenton		25C. FUNERAL DIRECTOR Joseph N. Zannino	
ADDRESS 263 S. Conkling Street					

4-2-73

Department of

Education

University of California - Berkeley

Department of Political Science

Some faculty agricultural extension

No

31 Jan

11-1-73
68

for Jan

X

Department of
August D. King Jr. M.D.

1902 24 Jan 24

1/2/73

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1274	
B-650 68-1274				CERTIFICATE OF DEATH	
BIRTH NO.				2	
1. NAME OF DECEASED (Type or Print) FLORENCE BROWN			2. DATE AND HOUR OF DEATH 1-27-68 1:45 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 27-10 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 833 WOODBOURNE ROAD AVE		
5. SEX FEMALE	6. RACE NEGROID	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-25-96	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME LEE REDD			14. MOTHER'S MAIDEN NAME EMMA RICHARDSON		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 486X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 7 days		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 21 1968 to Jan 27 1968, that (I) (we) last saw the deceased alive on Jan 27 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Henry M Thomas III				23B. DATE SIGNED 1/27/68	
23C. PHYSICIAN'S NAME (Type) HENRY M THOMAS III				23D. ADDRESS Johns Hopkins	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/31/68		24C. NAME OF CEMETERY OR CREMATORY Morgan Baptist Church	
24D. LOCATION Fryersville		24E. (City, town, or county) V.A.		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. FEB 1 1968		25B. NAME OF REGISTRAR R. E. F. F. F.		25C. FUNERAL DIRECTOR 1212 W. W. W. Ave	

X

IT/1

FOR THE COURT

XX

1000

Myself

James

no

no

no

no

no

no

Myself

James

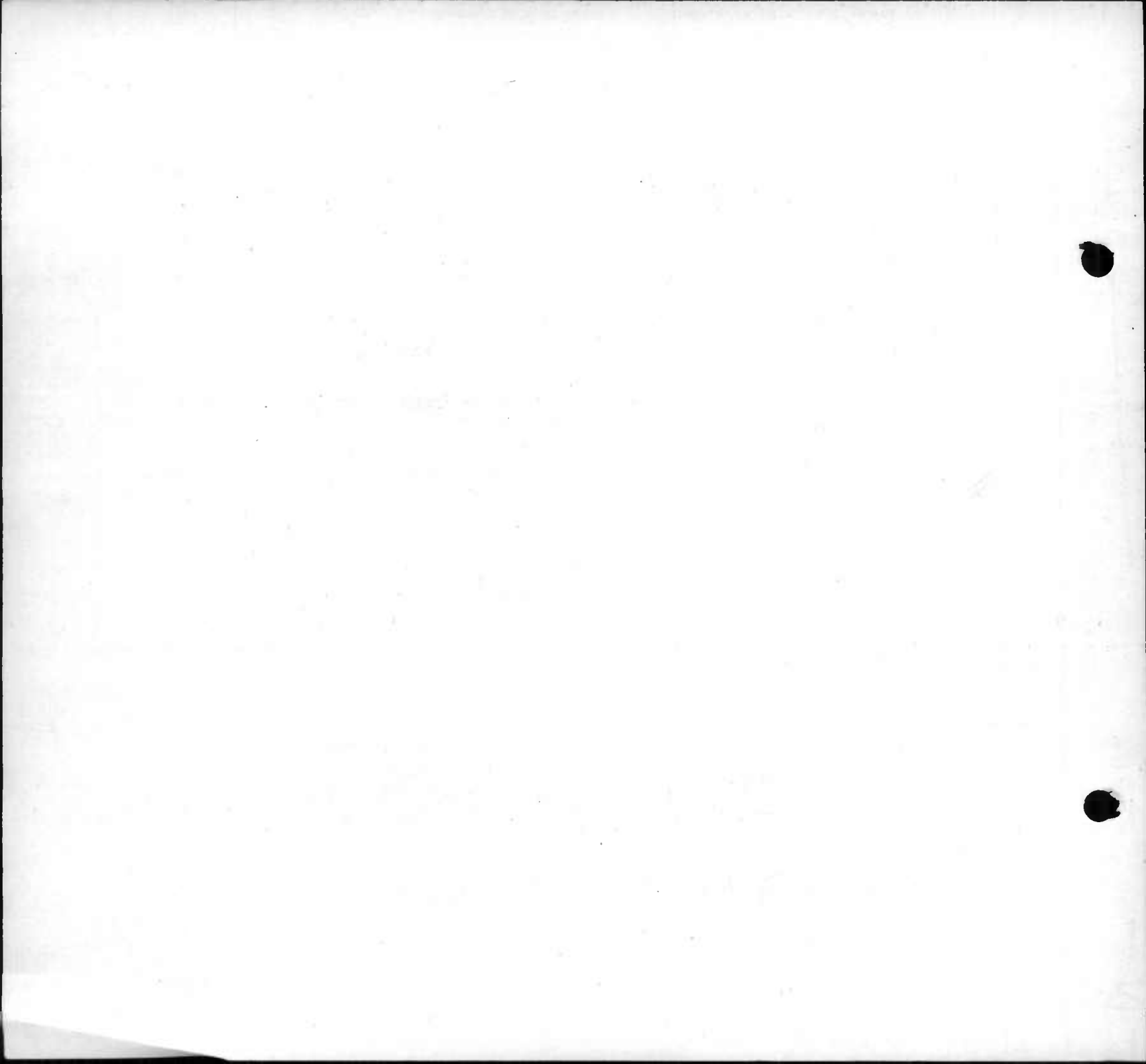
Myself

James

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 1275
N-620		68- 1275		CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Elva L. Norris		
2. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH 2/1/68 0005 A.		
FULL NAME OF HOSPITAL OR INSTITUTION Maryland Gen. Hosp.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY 27-09		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 1368 Pentwood Rd.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		8. DATE OF BIRTH 05/09/78		9. AGE (In years last birthday) 89
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Denton Gehr		14. MOTHER'S MAIDEN NAME Anna Light		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-54-2843		17. INFORMANT Mr Frank B Norris Jr. ADDRESS Same
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: cardio-respiratory arrest		
		(B) coronary thrombosis DUE TO, OR AS A CONSEQUENCE OF:		
		(C) ASCVD		
420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		?		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 1/26/68 19 to 2/1/68 19, that (I) (we) last saw the deceased alive on 2/1/68 19 and that in my (aur) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE Ralph D. Raymond		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 2/1/68
23C. PHYSICIAN'S NAME (Type) Ralph REXMOND		23D. ADDRESS Maryland Gen. Hosp.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/1/68		24C. NAME of CEMETERY or CREMATORY Loudon Park
24D. LOCATION Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. FEB 1 1968		
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J Ruck Inc 5305 Harford Rd		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-520				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1276	
68-1276 CERTIFICATE OF DEATH							
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) KING, Elmer Earl				1/27/68 12:55 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) HOSPITAL OR INSTITUTION Veterans Administration Hospital 23 3900 Loch Raven Blvd. Baltimore, Maryland 21218				A. STATE Maryland		B. COUNTY 12-05	
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 133 E. North Ave.			
5. SEX Male	6. RACE Negriod	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/17/88	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truckdriver			10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph King				14. MOTHER'S MAIDEN NAME Mary Richardson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 7/12/18 to 6/26/19		16. SOCIAL SECURITY NO. 218-03-8693		17. INFORMANT Records VAH, Balto., Md. 21218		ADDRESS	
18. CAUSE OF DEATH 4129 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Cardiac Arrythmea ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 433.1 II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 Minutes Several Years			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work		21F. HOW DID INJURY OCCUR?			
22. I certify that he (this hospital) attended the deceased from January 11, 1968 to January 27, 1968 , that he (we) last saw the deceased alive on January 27, 1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) view the body after death.							
23A. SIGNATURE David A. Shafretz MD				23B. DATE SIGNED 1/27/68			
23C. PHYSICIAN'S NAME (Type) DAVID A. SHAFRETZ				23D. ADDRESS VAH 3900 Loch Raven Blvd. Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-31-68		24C. NAME OF CEMETERY or CREMATORY Balt National Cem Balto		24D. LOCATION (City, town, or county) (State) Md	
25A. DATE REC'D BY HEALTH DEPT. FEB 1 1968		25B. NAME OF REGISTRAR Robert E. Sanders		25C. FUNERAL DIRECTOR Rayner Sanders		ADDRESS 217 E. Preston St	

13. H. Ford

WV

Virginia

Wm. H. Ford

Wm. H. Ford, Jr.

13. H. Ford

Wm. H. Ford

WV

0

Wm. H. Ford, Jr.

Wm. H. Ford

WV

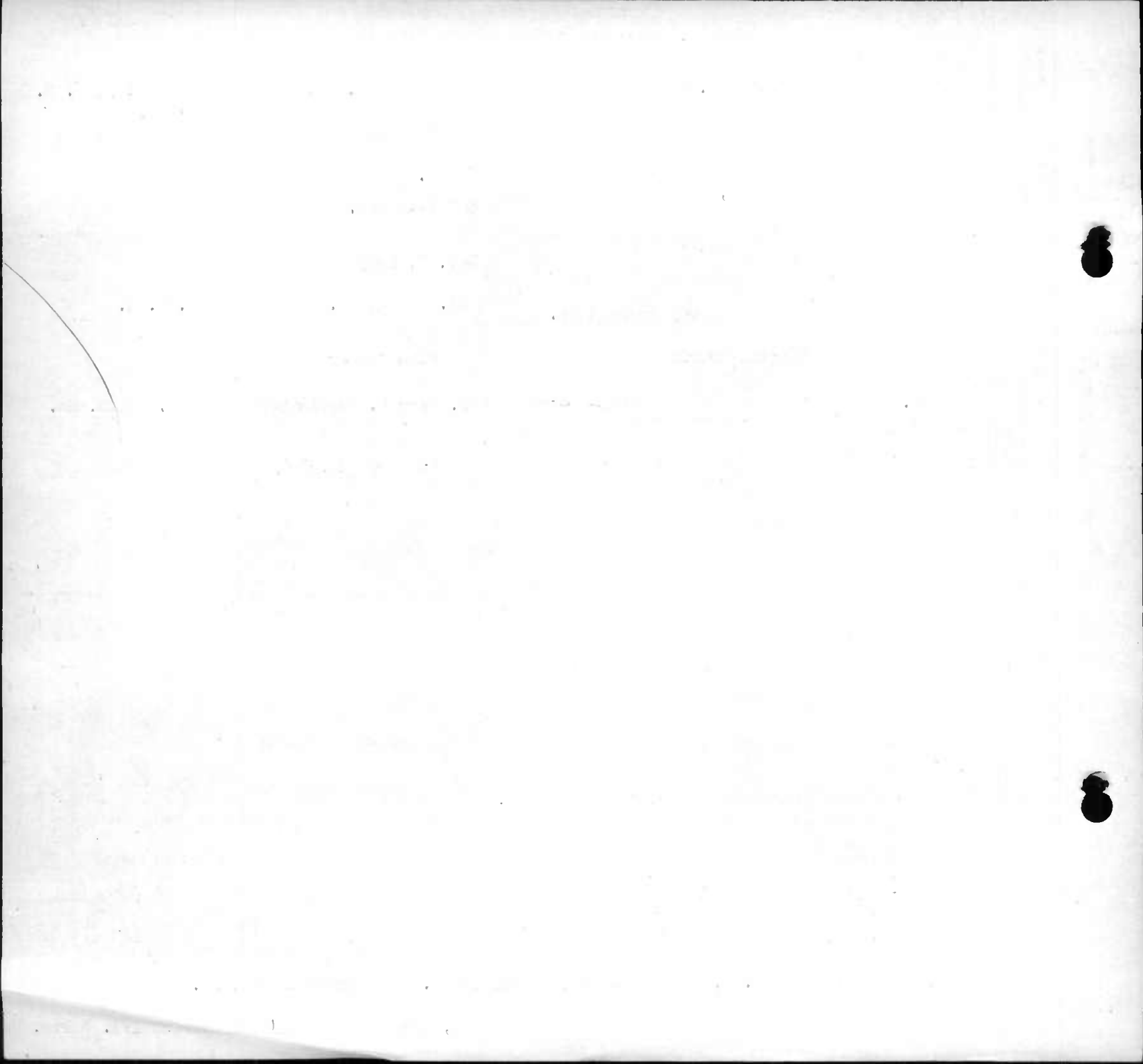
Wm. H. Ford, Jr.

Wm. H. Ford, Jr.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

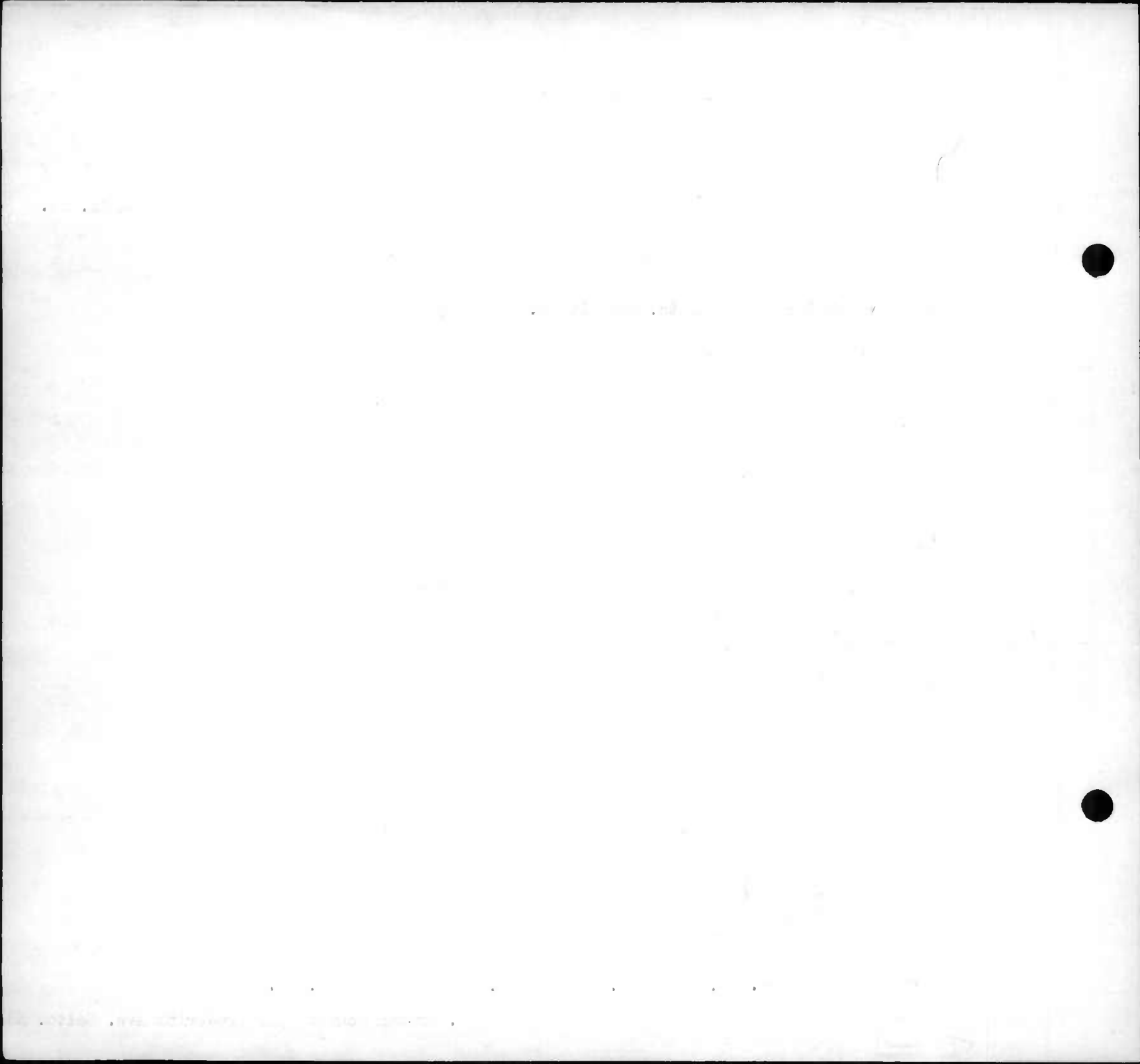
BALTIMORE CITY HEALTH DEPARTMENT				68-- 1277
68- 1277. CERTIFICATE OF DEATH				REG. NO.
BIRTH NO. M-620				
1. NAME OF DECEASED (Type or Print) William H. Morris		2. DATE AND HOUR OF DEATH Jan. 30, 1968 4: 30 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 502 Yale Ave,		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 502 Yale Ave.		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 6, 1909	9. AGE (In years last birthday) 58
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10B. KIND OF BUSINESS OR INDUSTRY Guy Ireland Co.		11. BIRTHPLACE (State or foreign country) Mt. Carmal Pa.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Charles Morris		
14. MOTHER'S MAIDEN NAME Elva Wagner		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		
16. SOCIAL SECURITY NO. 178-01-4899		17. INFORMANT Mrs. Mary L. Morris 502 Yale Ave. Balto. Md.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 412.9 I ANTERIOSEPTIC CARDIOVASCULAR DISEASE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 YRS		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 422.1 II				
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
21A. DATE OF OPERATION	21B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 5/25 19 64 to 1/30 19 68 , that (I) (we) last saw the deceased alive on 1/25 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Thomas E. Roach		23B. DATE SIGNED 1/30/68		
23C. PHYSICIAN'S NAME (Type) Thomas E. Roach		23D. ADDRESS 5550 Badru Natl Pk Baltimore		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE Feb. 1, 1968	24C. NAME OF CEMETERY or CREMATORY Lakeview Memorial Cem.		24D. LOCATION (City, town, or county) (State) Randallstown, Md.
25A. DATE REC'D BY HEALTH DEPT. FEB 1 1968		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR G. Truman Schwab 3512 Frederick Ave. Balto. Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

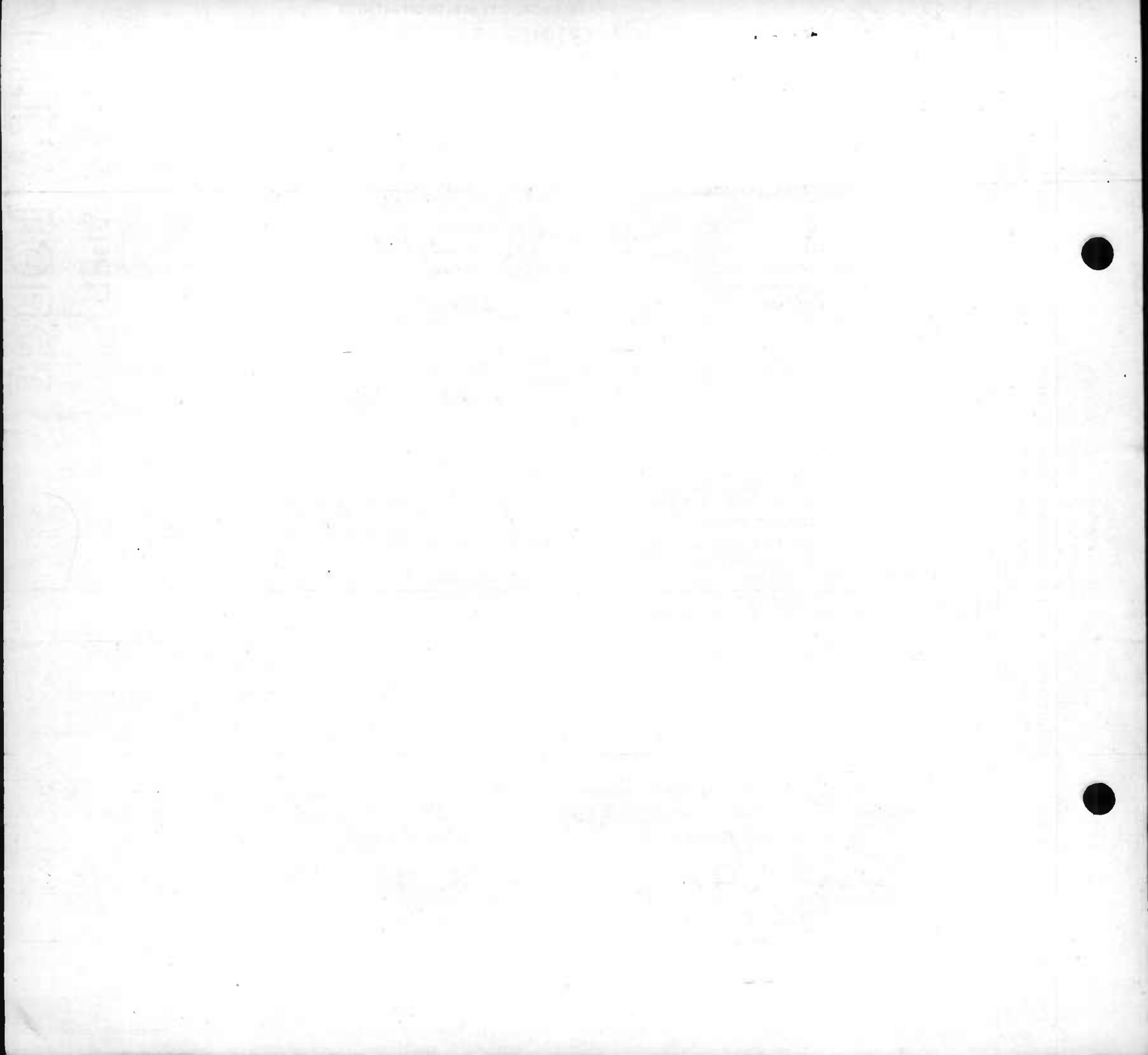
P-620 BIRTH NO.		68- 1278 CERTIFICATE OF DEATH		Registered No. 68- 1278	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) PARKS, MARGARET		2. DATE AND HOUR OF DEATH 1/28/68 12 50 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) NORTH CHARLES GEN. HOSP.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balto. Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 63-00 D. STREET ADDRESS (If rural, give location) 3624 BALTIMORE ST. Balto. Co.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W.	8. DATE OF BIRTH 5-27-80	9. AGE (In years last birthday) 87 yrs.	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Armature Winder		10B. KIND OF BUSINESS OR INDUSTRY Balto. Transit Co.		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME CHRISTIAN NAZAENRUS		14. MOTHER'S MAIDEN NAME MARIA SLAD			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213 109831		17. INFORMANT PATIENT'S CHART	
18. 153.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CARDIO-RESPIRATORY FAILURE		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CA OF TRANSVERSE Colon (OPERATED) & METASTASIS		(B) DUE TO (C)			
153.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 1/26/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED INTESTINAL OBSTRUCTION		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/30 1967 to 1/28 1968 , that (I) (we) last saw the deceased alive on 1/28 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Honorata M. Bengzon		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/28/68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan. 31, 1968		24C. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. FEB 1 1968			
25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR G. Truman Schwab 3512 Frederick Ave. Balto. Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 1279	
P- 363 68- 1279 CERTIFICATE OF DEATH					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <i>Benedict Petraitis</i>			2. DATE AND HOUR OF DEATH <i>Jan 30 1968</i> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>19-03</i>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>1421 West Lombard St</i>			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <i>1421 West Lombard St</i>					
5. SEX <i>M</i>	6. RACE <i>wh</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 20 1891</i>	9. AGE (In years last birthday) <i>76</i>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tailor</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Uniforms</i>	11. BIRTHPLACE (State or foreign country) <i>Lithuania</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>218-36-8383</i>		17. INFORMANT <i>John Petraitis 5105 Circle Pl Balto Md 27</i>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>420.1 II</i>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute Myocardial Infarction</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary Thrombosis</i> (C) DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic Heart Disease</i>		
19. DATE OF OPERATION			20A. AUTOPSY? (Yes or No)		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 67</i> to <i>Jan 68</i> that (I) (we) last saw the deceased alive on <i>Dec 19 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Geo Vash</i>			23B. DATE SIGNED <i>1/30/68</i>		
23C. PHYSICIAN'S NAME (Type) <i>GE6 VASH</i>			23D. ADDRESS <i>206 S. S. S. S.</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>2-1-68</i>	24C. NAME OF CEMETERY or CREMATORY <i>Louisa Park Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Balto Md.</i>
25A. DATE REC'D BY HEALTH DEPT. <i>FEB 1 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Thos J Kenny Inc 1600 Hollins St</i>	



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. **68-1280**

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARGARET L. EDMAN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> January 29, 1968 4:55 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year January 29, 1968 4:55 P. M.	
6. SEX Female	7. RACE White	5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Jan. 29, 1904		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10. AGE (In years lost birthday) 64		E. STREET AND NUMBER 5412 Addington Road	
11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert L. Hodson		14. MOTHER'S MAIDEN NAME Sarah M. Merchant	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		14B. KIND OF BUSINESS OR INDUSTRY --	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Eleanor Glaeser		ADDRESS 5412 Addington Rd.	
18. CAUSE OF DEATH Carcinoma of Lung		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 163X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-30-68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-1-1968	
24C. NAME of CEMETERY or CREMATORY Greenmount		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. FEB 1 1968		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR G. Howard Strong		ADDRESS 3207 W. North Ave.,	

100-1000

100-1000

100-1000

100-1000

100-1000

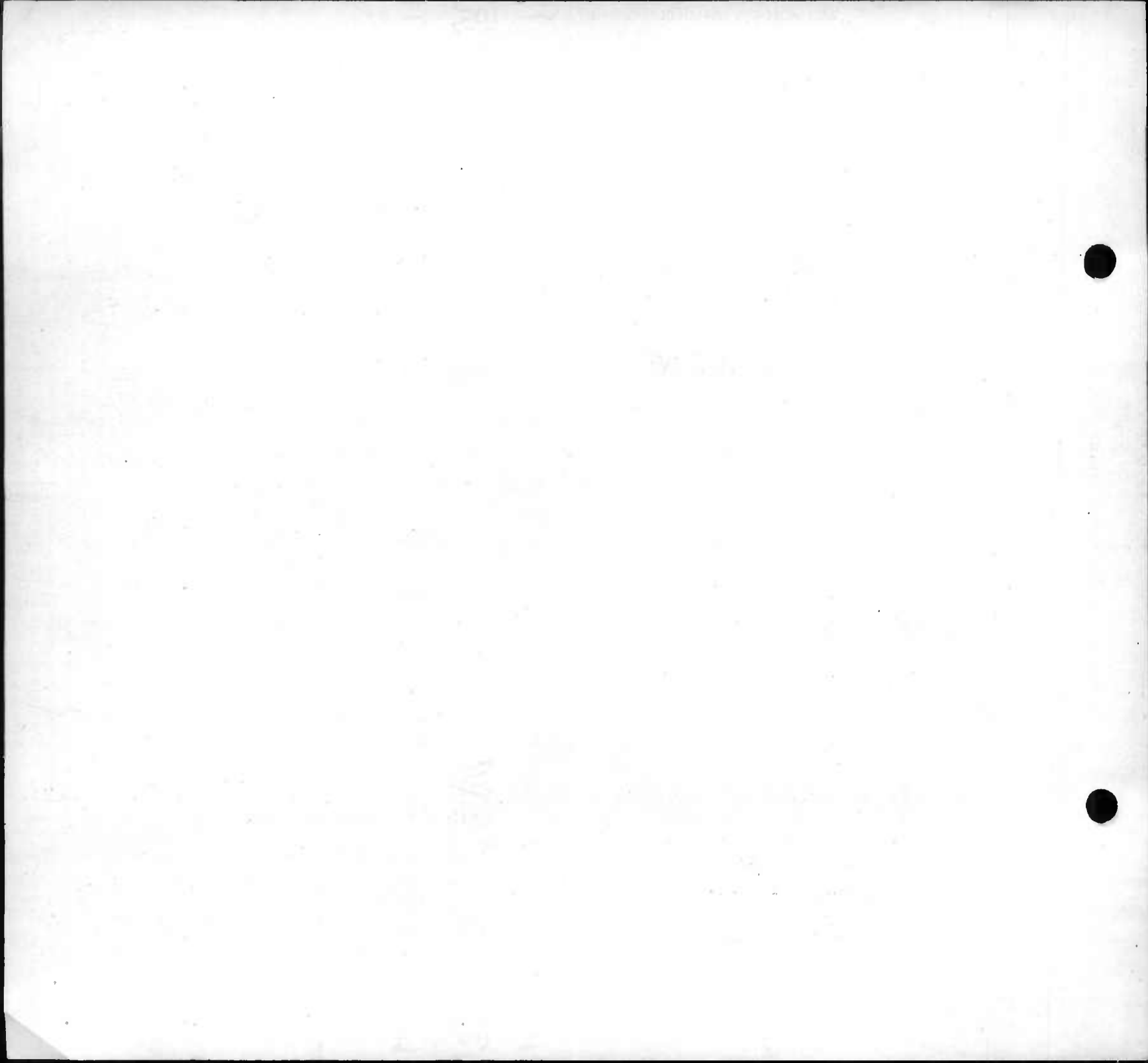
100-1000

100-1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

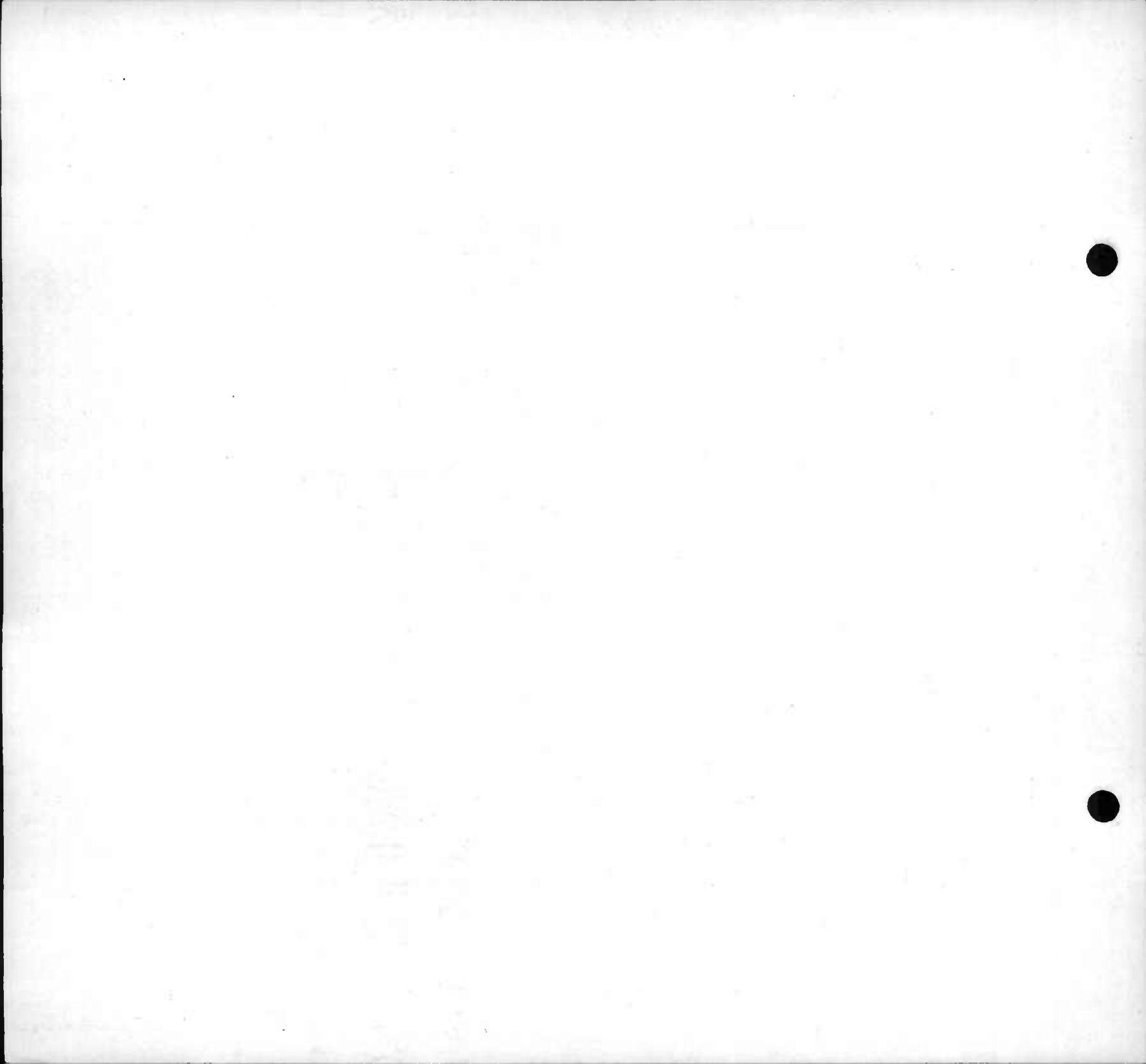
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 1281	
<div style="display: flex; justify-content: space-between;"> L-520 68- 1281 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) LILLIAN E LINK			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH 1-31-68 1:10 PM			
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GEN. Hosp.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 28-03		C. CITY OR TOWN BALTO	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 2015 OAK DR	
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-26-04	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) BALTO MD	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME EDWARD LAMBDEN		14. MOTHER'S MAIDEN NAME EMMA WICKS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-469535		17. INFORMANT JOHN LINK	
18. 723.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) GRAM NEG. SEPTICEMIA		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: OSTEOPOROSIS - FRACTURE (B) SPINE - PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF: (C) —		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12-14 hr	
19. 733X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). LONG TIME USE OF PREDISONE					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes, or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from 11-26-1967 to 1-31-1968 , that (I) (we) last saw the deceased alive on 1-31-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Larry Thobel MD				23B. DATE SIGNED 1-31-68	
23C. PHYSICIAN'S NAME (Type) GARY L. NOBEL MD		23D. ADDRESS 2903-A ANDORRA CT BALTO MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-3-68		24C. NAME OF CEMETERY or CREMATORY Loudon Park	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. FEB 1 1968			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR G. Howard Strong			
ADDRESS 3207 W. North Ave.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-200				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1282	
68-1282				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ARTHUR N. LEGO				2. DATE AND HOUR OF DEATH 1/30/68 1145 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 MARYLAND GENERAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 27-09			
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1631 Northgate Rd.			
5. SEX MALE	6. RACE CAUC	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/27/07		9. AGE (In years last birthday) 60	10. If Under 1 Yr. Months: Days: Hours: Min. - - - -
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MUSICIAN				10B. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME ARTHUR LEGO			
14. MOTHER'S MAIDEN NAME ADA ARNOLD				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 215-01-5873				17. INFORMANT PREV. Admission			
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cancer of the lung with metastasis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9/28/67			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 163X II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ---							
20A. DATE OF OPERATION No		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED ---		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? ---	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ---		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ---		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) ---			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) ---		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? ---			
22. I certify that (I) (this hospital) attended the deceased from 12/31 19 67 to 1/30 19 68 , that (I) (we) last saw the deceased alive on 1/29 19 68 and that in (my) (the) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.							
23A. SIGNATURE C. J. De Felice				23B. DATE SIGNED 1/30/68		23C. PHYSICIAN'S NAME (Type) C. De Felice	
23D. ADDRESS Md Gen. Hosp.				23E. DEGREE ---		23F. DEGREE ---	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/2/68		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery		24D. LOCATION (City, town or county) (State) Windsor Mill Rd, Md	
25A. DATE REC'D BY HEALTH DEPT. FEB 2 1968		25B. NAME OF REGISTRAR Robert E. Taylor, Md		25C. FUNERAL DIRECTOR Austin E. Donovan		25D. ADDRESS 3818 Roland Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-1283</u>
B-635		68-1283		CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Cecelia Bartnicki</u> (SKY)		
2. DATE AND HOUR OF DEATH		1/30/68 12:20 p. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>South Baltimore General Hospital</u>		A. STATE <u>Maryland</u>		
		C. CITY OR TOWN <u>Baltimore</u>		
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>4527 Pennington Avenue</u>				
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/31/88</u>	9. AGE (In years lost birthday) <u>79</u> <u>80</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>POLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>John Kulwicki</u>		14. MOTHER'S MAIDEN NAME <u>MARY</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>FAMILY</u> ADDRESS <u>Same</u>
18. <u>25-0191</u>		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Chronic cong. heart failure</u>		
ANTECEDENT CAUSES		(B) <u>Diabetes mellitus</u> DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <u>ASA HD, Bronchopneumonia</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (X) (this hospital) attended the deceased from <u>1/17/68</u> 19 to <u>1/30/68</u> 19, that (X) (we) lost saw the deceased alive on <u>1/30/68</u> 19 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Donald M. Wood, M.D.</u>				23B. DATE SIGNED <u>1/30/68</u>
23C. PHYSICIAN'S NAME (Type) <u>DONALD M. WOOD M.D.</u>				23D. ADDRESS <u>S.B.G.H. - 1213 Light Street</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>2-3-68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cross Cem</u>
24D. LOCATION (City, town, or county) (State) <u>Balto 21225</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 2 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber</u>		25C. FUNERAL DIRECTOR <u>John H. Hall Funeral Home</u> ADDRESS <u>4200 Pennington Ave Balto 21226, Md</u>

10-11-1941

10-11-1941

No

10-11-1941

L-200

68-1284

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-1284

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)
LEWIS

HARVEY

2. DATE
OF
DEATHKnown ☐

Month

Day

Year

Hour

Estimated ☒

January 19, 1968

3:30 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

12 N. Caroline Street

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

January 19, 1968

3:30 P. M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
Maryland

B. COUNTY

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

10. AGE (In years
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

12 N. Caroline Street

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

19. 412.91

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

422.1 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/20/68

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

1-25-68

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

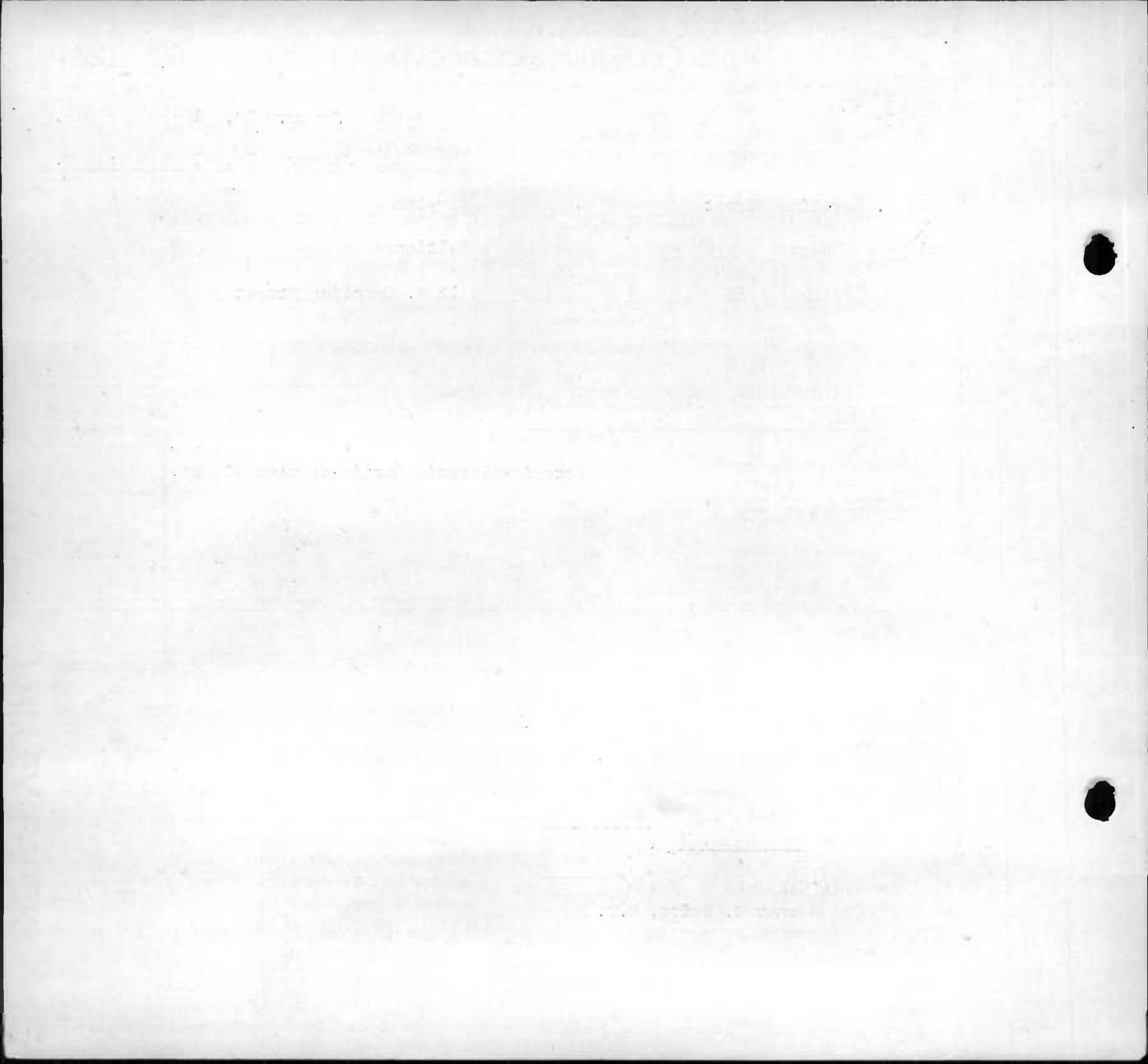
25C. FUNERAL DIRECTOR

ADDRESS

FEB 2 1968

Robert E. Fisher, M.D.

HOSPITAL DISPOSAL



R-320

68-- 1285

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-- 1285

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RICHARD REDDICK		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> January 26, 1968 4:45 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1240 Edythe Street		3. DATE PRONOUNCED DEAD Month Day Year Hour January 26, 1968 4:45 A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY S-01	
9. DATE OF BIRTH		10. AGE (In years last birthday) 68 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME		18. INFORMANT ADDRESS	
19. 412.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-26-68			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 2-1-68	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City town or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. FEB 2 1968		25B. NAME OF REGISTRAR Robert E. Fairburn	
25C. FUNERAL DIRECTOR		25D. ADDRESS HOSPITAL DISPOSAL	

H-325

68-1286 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-1286

REG. NO.

BIRTH NO.

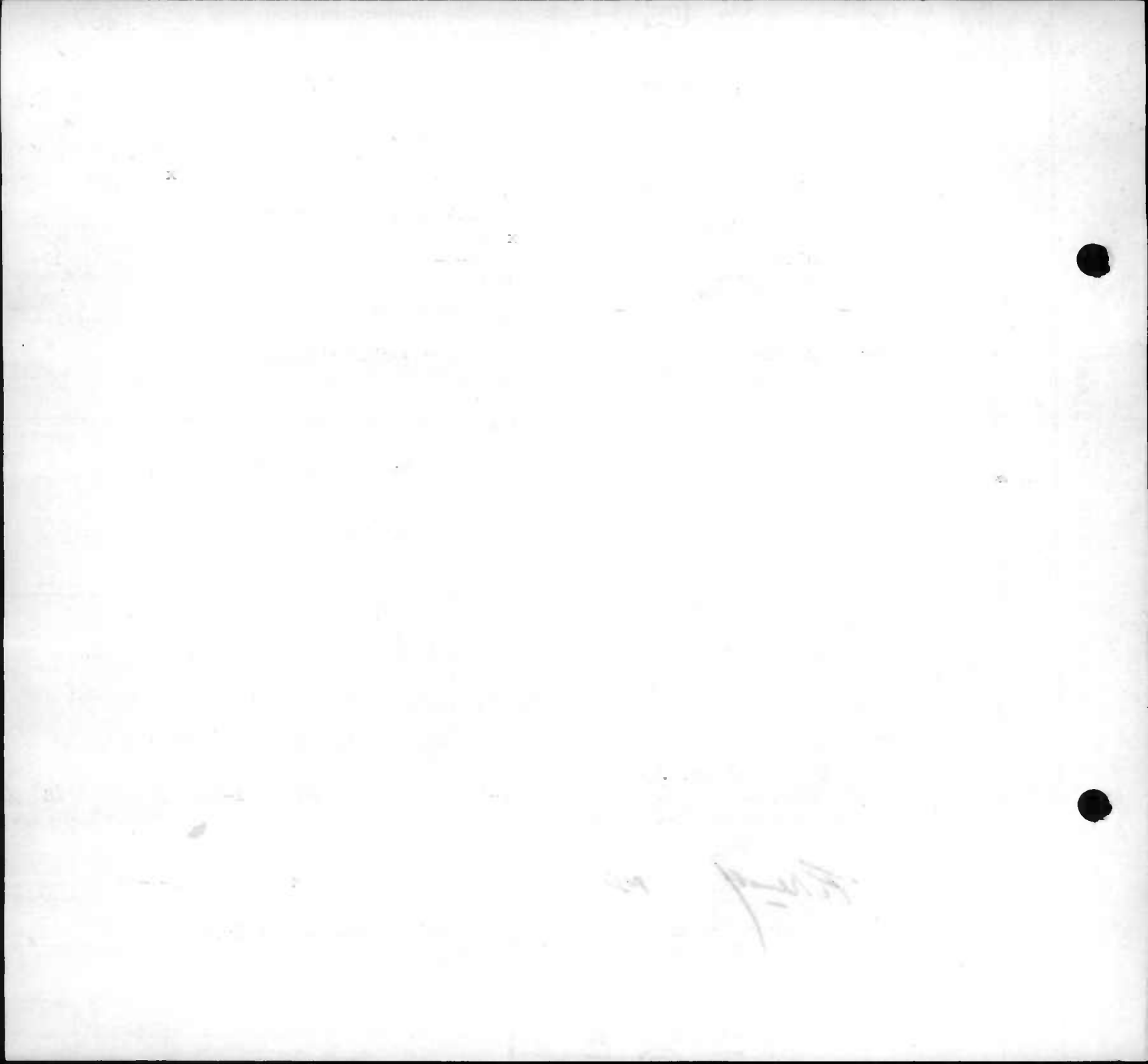
1. NAME OF DECEASED (Type or Print) JESSE TUCKER HUDSON, JR.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 135 N. Broadway		3. DATE PRONOUNCED DEAD Month Day Year Hour January 4, 1968 5:20 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 6-05	
9. DATE OF BIRTH		10. AGE (In years last birthday) 59	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		18. SOCIAL SECURITY NO.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 412.0 I Hypertensive cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: 443.x II Bronchial asthma OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED January 4, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 2-1-68	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. FEB 2 1968		25B. NAME OF REGISTRAR Robert E. [Signature]	
25C. FUNERAL DIRECTOR		25D. ADDRESS HOSPITAL DISPOSAL	

WILLIAM PROCTOR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

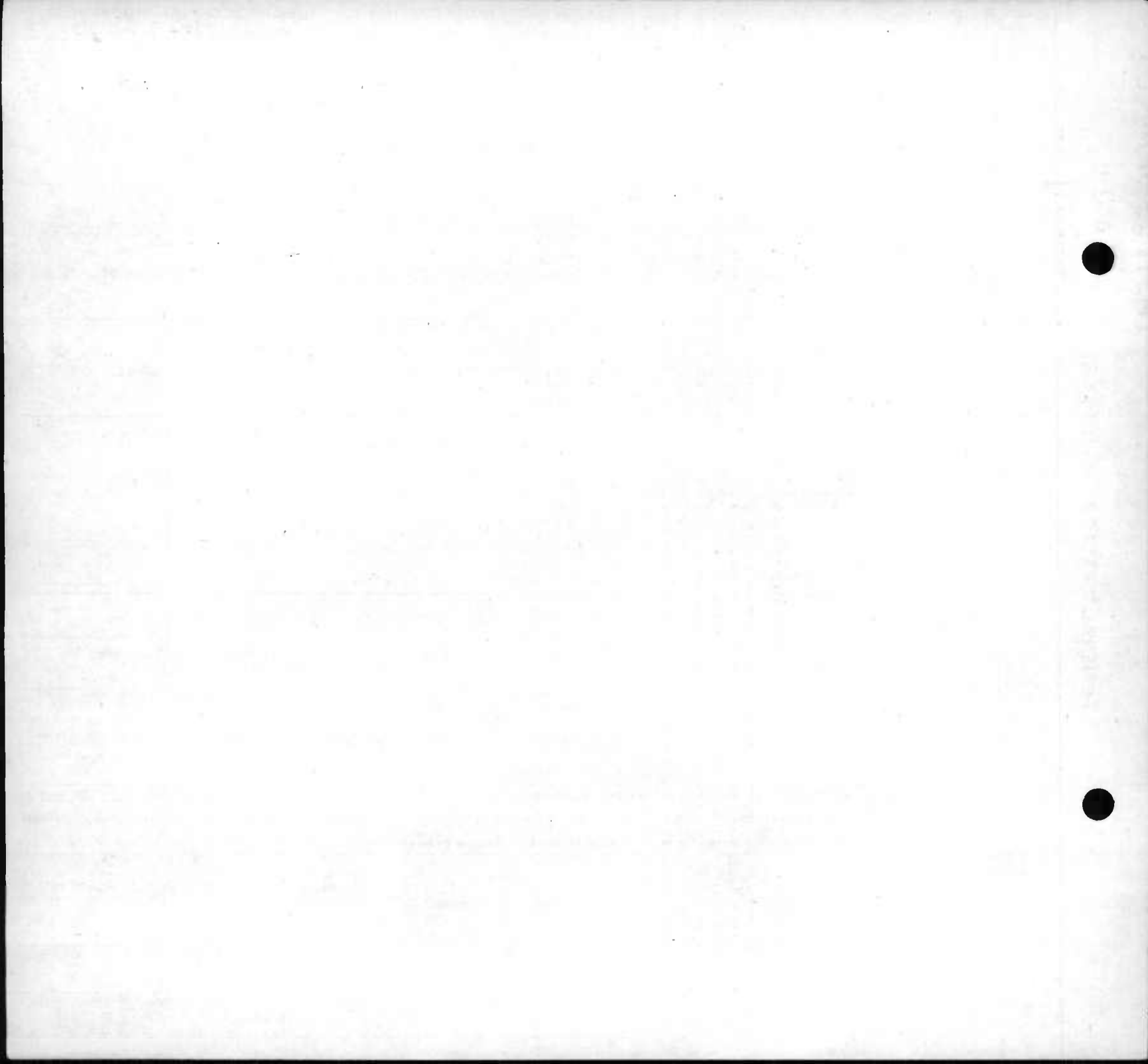
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1287	
<div style="display: flex; justify-content: space-between;"> A-425 68-1287 </div>				CERTIFICATE OF DEATH	
BIRTH NO. 68-00253				DATE AND HOUR OF DEATH 1/4/68 2 p. M.	
1. NAME OF DECEASED (Type or Print) Alexander, Baby Girl					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 The Union Memorial Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____ C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 303 Wyman Park Drive	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-3-68	9. AGE (In years last birthday) 1-3-68	If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: 23 Min. 17
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Leonard Alexander				14. MOTHER'S MAIDEN NAME Marguerite Wilkins	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -		17. INFORMANT ADDRESS -	
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 50%;"> (A) IMMEDIATE CAUSE Hyaline Membrane disease DUE TO, OR AS A CONSEQUENCE OF: (B) Prematurity DUE TO, OR AS A CONSEQUENCE OF: (C) </div> </div>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 773.5 II					
19A. DATE OF OPERATION -		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) _____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 1 4 68 2p.m.		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that (I) (this hospital) attended the deceased from 1-3 1968 to 1-4 1968, that (I) (we) last saw the deceased alive on 1-4 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 1-4-68	
23C. PHYSICIAN'S NAME (Type) Nahum Frenck				23D. ADDRESS Union Memorial Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) -		24B. DATE 1-26-68		24C. NAME OF CEMETERY or CREMATORY -	
25A. DATE REC'D BY HEALTH DEPT. FEB 2 1968		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR -	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

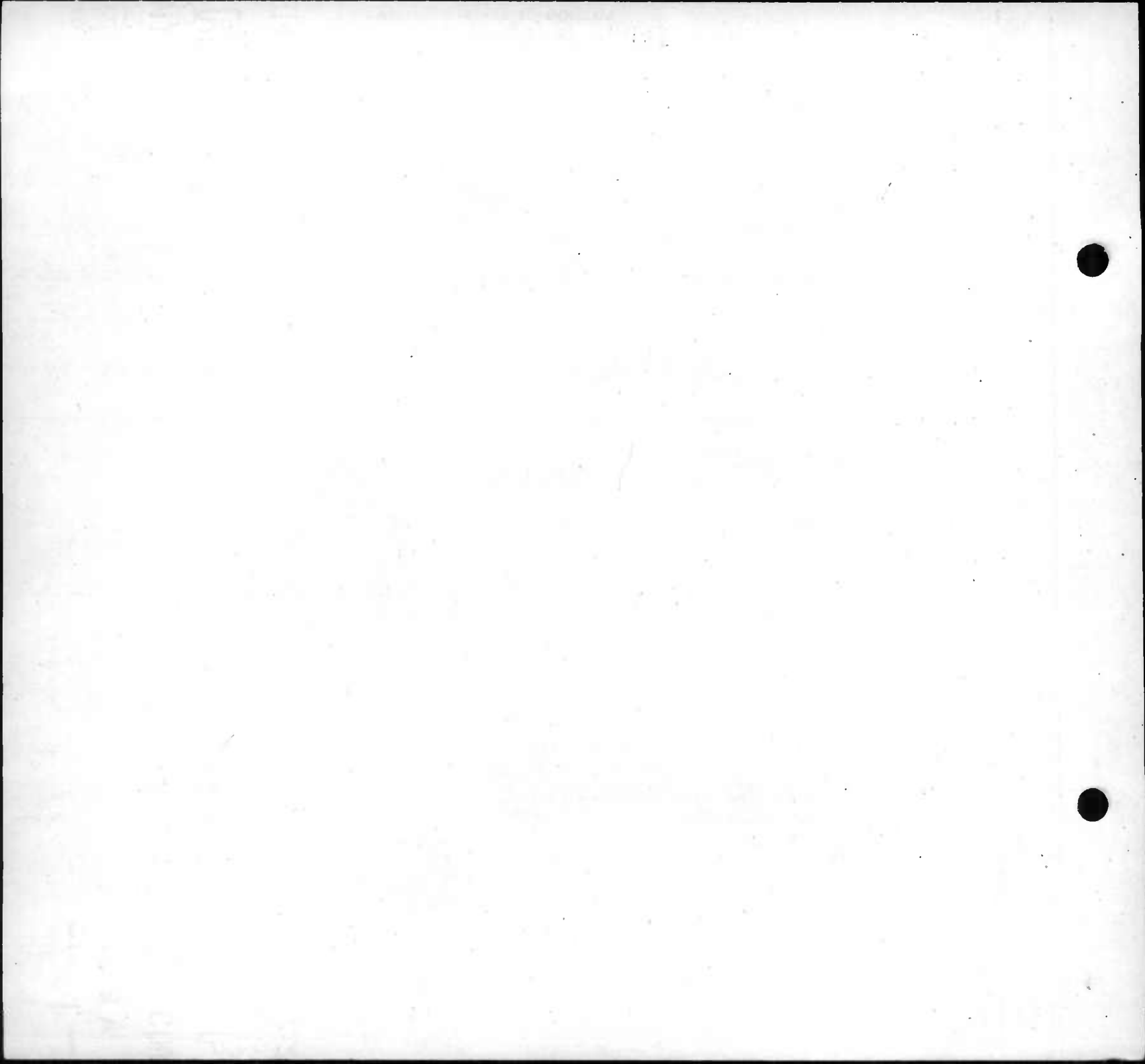
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1288	
BIRTH NO. 5-165		68-1288 CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Albert Sprinkle		2. DATE AND HOUR OF DEATH Jan. 23, 1968 11:15 A.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 90 Century Home 102 No. Paca St.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 4-02 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 102 N. PACA ST	
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/24/80
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 87
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212 18 8427A	17. INFORMANT ADDRESS
18. 4-12-9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardio-Respiratory Failure Chronic Heart Failure Arteriosclerotic CVD Bronchopneumonia Generalized Cerebral Arteriosclerosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Cardio-Respiratory Failure Chronic Heart Failure Arteriosclerotic CVD Bronchopneumonia Generalized Cerebral Arteriosclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 3 19 66 to 1/23 19 68 , that (I) (we) last saw the deceased alive on 1/23/68 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.			
23A. SIGNATURE Willard Applefez		23B. DATE SIGNED 1/23/68	
23C. PHYSICIAN'S NAME (Type) Willard Applefez		23D. ADDRESS 5615 Reisterstown Rd Baltimore MD	
24A. BURIAL CREMATION, REMOVAL (Specify) 2-1-68		24B. DATE	
24C. NAME OF CEMETERY OR CREMATORY JOHNS HOPKINS MEDICAL SCHOOL		24D. LOCATION (City, town or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. FEB 2 1968		25B. NAME OF REGISTRAR Robert E. Farkner	
25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

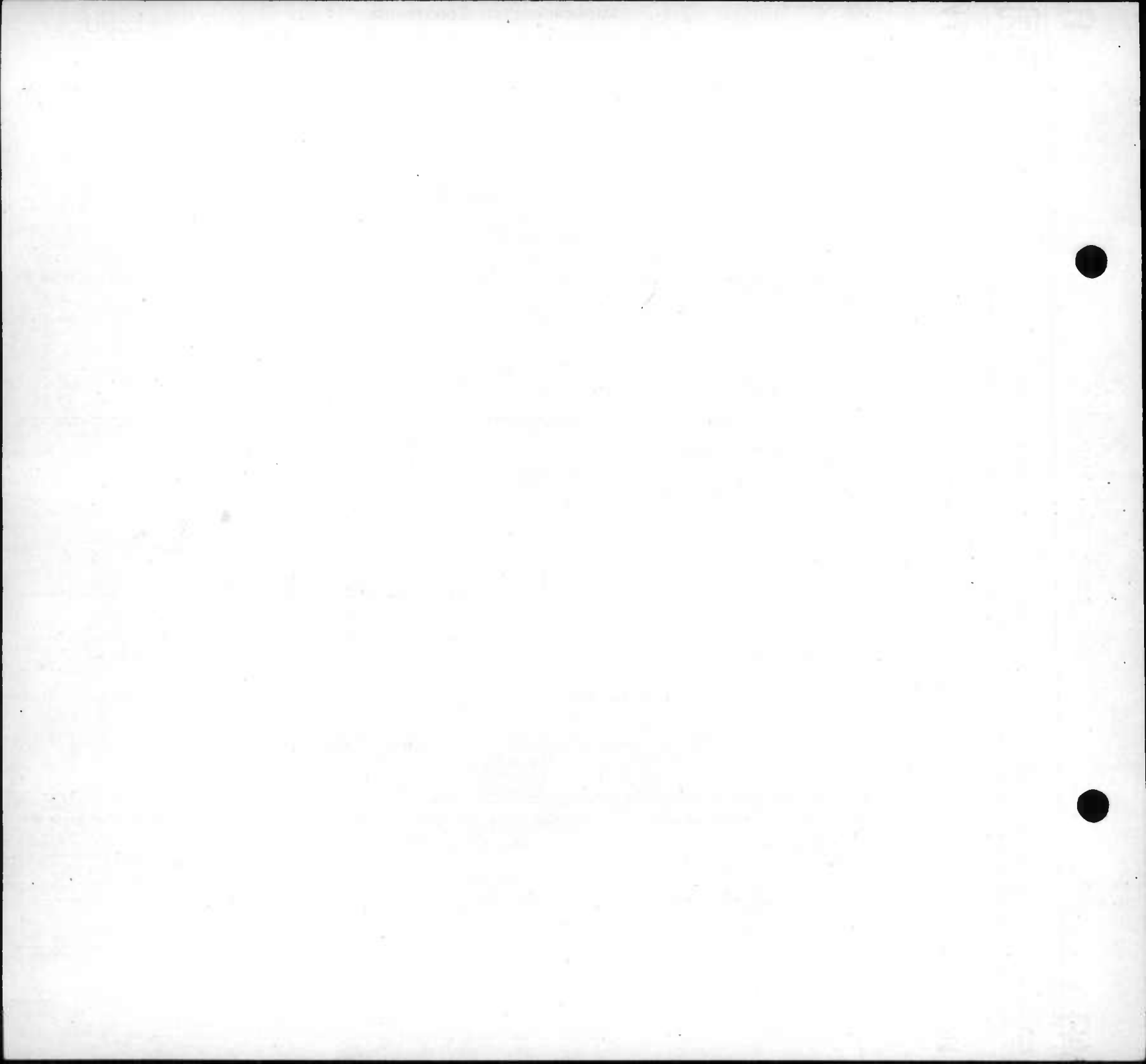
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1289 4
J-516 BIRTH NO. 68-00965		68-1289 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) BABY BOY JENNIFER		2. DATE AND HOUR OF DEATH 1-20-68 10:50 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSPITAL OF MD.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 16-07 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2944 WINCHESTER ST.		
5. SEX M	6. RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-19-68	9. AGE (In years lost birthday) 16 20
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.
13. FATHER'S NAME JOHN E. JENNIFER		14. MOTHER'S MAIDEN NAME MARTHA MORTON		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT CHART ADDRESS
18. 776.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 762.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Aspiration pneumonia (B) Cerebral Anoxia (C) Respiratory Depression Cerebral Heart Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 1-19-1968 to 1-20-1968 , that (I) (we) lost saw the deceased alive on 1-20-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE S. Aziz		23B. DATE SIGNED 1-20-68		23C. PHYSICIAN'S NAME (Type) S. Aziz
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1-25-68		24C. NAME OF CEMETERY OR CREMATORY ANATOLY BOARD OF MARYLAND
25A. DATE REC'D BY HEALTH DEPT. FEB 2 1968		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR 730 ASHBURTON ST. BALTO. MD 21216
UNIVERSITY MEDICAL SCHOOL HOSPITAL DISPOSAL				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. of a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

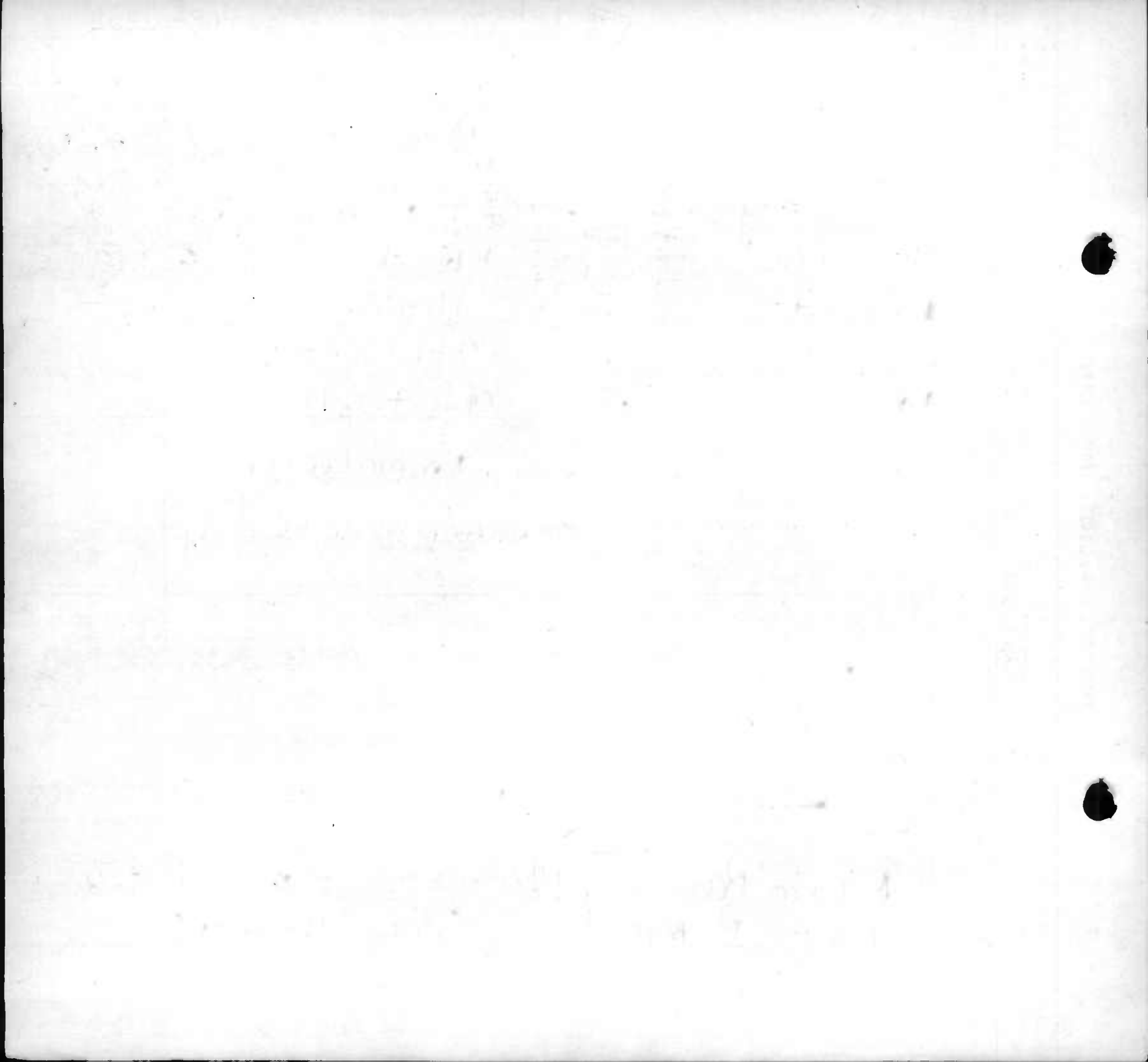
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1290
BIRTH NO. D-625 68-01345 68-1290		CERTIFICATE OF DEATH		
1. NAME OF DECEASED <small>(Type or Print)</small> BABY GIRL DRAUGHN 'A' TWIN		2. DATE AND HOUR OF DEATH 1-24-68 12.00 NOON		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <small>(If not in hospital or institution, give street address or location)</small> 46 LUTHERAN HOSPITAL OF MARYLAND		4. USUAL RESIDENCE <small>(Where deceased lived. If institution: residence before admission)</small> A. STATE MD. B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1537 N. FULTON AVE		
5. SEX F	6. RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-22-68	9. AGE <small>(In years last birthday)</small> 2
10A. USUAL OCCUPATION <small>(Give kind of work done during most of working life, even if retired)</small>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE <small>(State or foreign country)</small>
13. FATHER'S NAME NATHANIEL		14. MOTHER'S MAIDEN NAME PAULETTE BOOZER		
15. Was Deceased Ever in U. S. Armed Forces? <small>(Yes, no or unknown) (If yes, give war or dates of service)</small>		16. SOCIAL SECURITY NO.		17. INFORMANT CHART ADDRESS
18. 778.2 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> (A) IMMEDIATE CAUSE RESPIRATORY DISTRESS SYNDROME DUE TO, OR AS A CONSEQUENCE OF: </div> <div style="width: 45%;"> (B) PREMATURITY DUE TO, OR AS A CONSEQUENCE OF: </div> </div> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> (C) PULMONARY HAEMORRHAGE </div> <div style="width: 45%;"> </div> </div>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

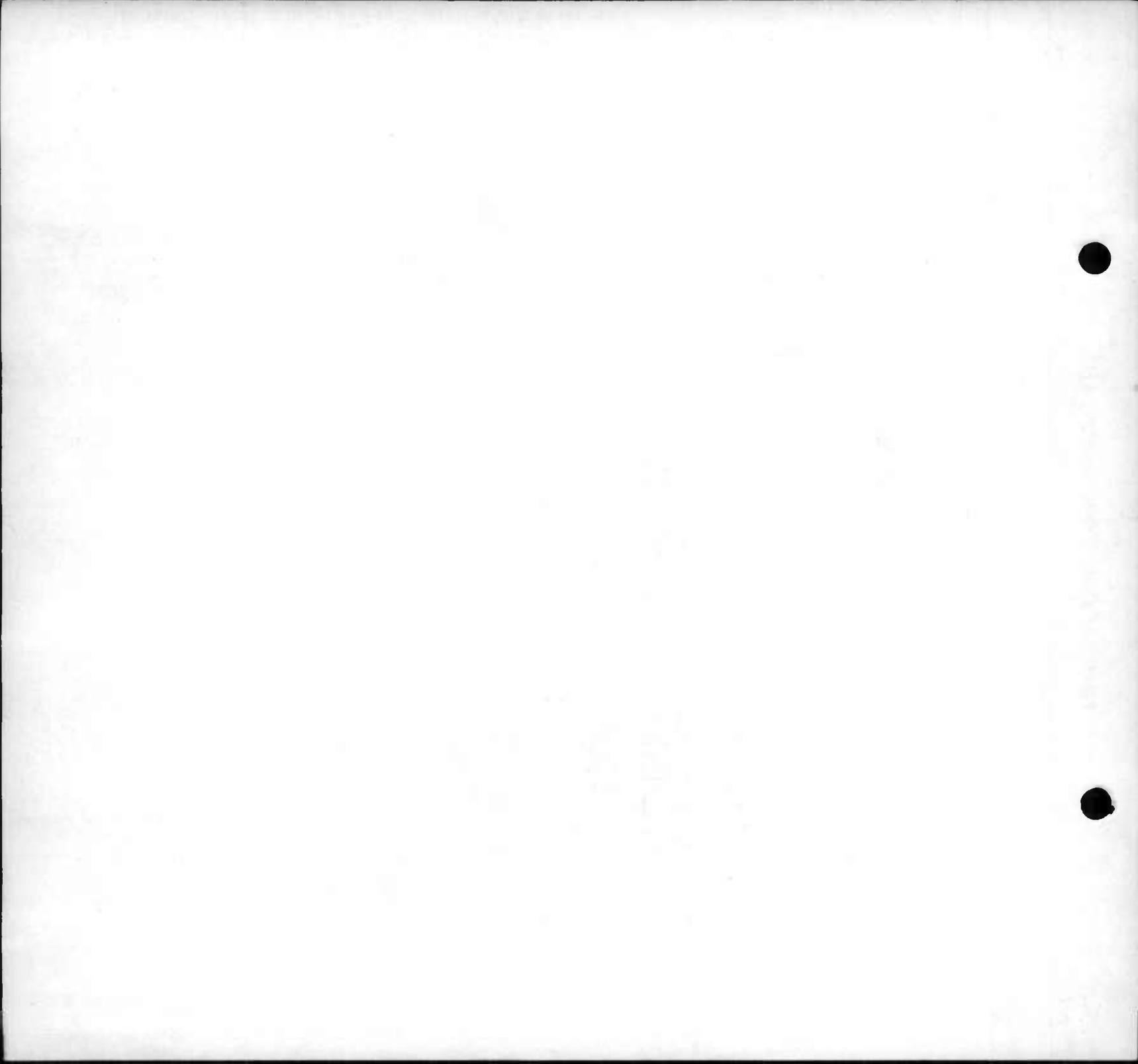
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 1291
C-620 68- 1291 CERTIFICATE OF DEATH				f
BIRTH NO. 68-01714		1. NAME OF DECEASED (Type or Print) BABY GIRL CHRISCOE		
2. DATE AND HOUR OF DEATH 1-15-68		930 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital of Balto, Inc.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 15-66 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1703 Bloomingtonale Rd.		
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-15-68	9. AGE (in years lost birthday) 0 0 0 45 If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10B. KIND OF BUSINESS OR INDUSTRY 0		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME		
14. MOTHER'S MAIDEN NAME CHRISCOE		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. -		17. INFORMANT Chart of Hospital ADDRESS		
18. 773X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Immaturity DUE TO, OR AS A CONSEQUENCE OF: (B) Spontaneous interruption of preg. DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. 774X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) 0
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 0		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (A.P.M.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 1-15-68 19 68 to 1-15 19 68 , that (I) (we) last saw the deceased alive on 1-15-68 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE Nina Rawlings		23B. DATE SIGNED 1-15-68		23C. PHYSICIAN'S NAME (Type) NINA RAWLINGS
23D. ADDRESS Sinai Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) 1-30-68		
24B. DATE 1-30-68		24C. NAME of CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL HOSPITAL DISPOSAL		
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. FEB 2 1968		
25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL		
25D. ADDRESS				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

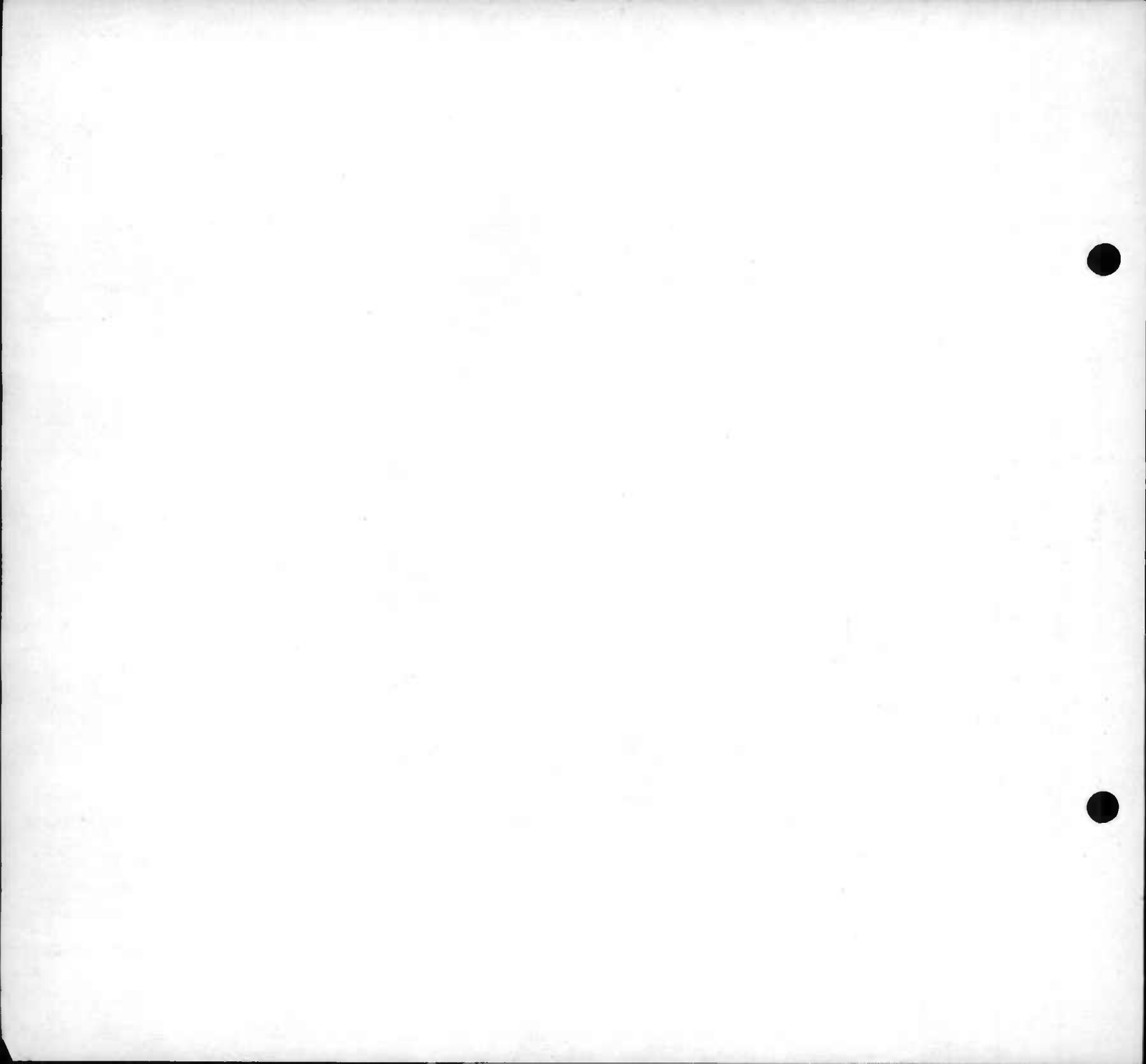
BALTIMORE CITY HEALTH DEPARTMENT BIRTH NO. <u>68-02759 68-1292</u> CERTIFICATE OF DEATH Registered No. <u>68-1292</u>			
M.E. CASE NO. _____ 1. NAME OF DECEASED (Type or Print) <u>Baby Boy Adams - "B"</u>		2. DATE AND HOUR OF DEATH <u>1/24/1968</u> - <u>5:00 A.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Hosinger Hospital of Baltimore, Inc.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____ C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>4730 Wakefield Rd.</u>	
5. SEX <u>M -</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) _____	8. DATE OF BIRTH <u>1/22/68</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10B. KIND OF BUSINESS OR INDUSTRY _____	9. AGE (In years last birthday) <u>46 yrs</u>
13. FATHER'S NAME <u>Robert Adams Jr.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
14. MOTHER'S MAIDEN NAME _____		17. INFORMANT <u>Chart</u> ADDRESS _____	
18. <u>776.2</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) <u>Neonatal Respiratory Distress Syndrome.</u>		INTERVAL BETWEEN ONSET AND DEATH _____	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO _____ (B) DUE TO <u>Prematurity</u> (C) _____	
MEDICAL CERTIFICATION <u>773.5</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <u>2</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____	20A. AUTOPSY? (Yes or No) <u>✓</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <u>1/22/1968</u> 19 <u>68</u> to <u>1/24</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1/23</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>I. Meyer Heller MD</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <u>1/24/1968</u>
23C. PHYSICIAN'S NAME (Type) <u>I. Meyer Heller MD</u>		23D. ADDRESS <u>Sing. Hospital Baltimore Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) _____	24B. DATE <u>1-30-68</u>	24C. NAME of CEMETERY or CREMATORY _____	
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 2 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley</u>	25C. FUNERAL DIRECTOR ADDRESS _____



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

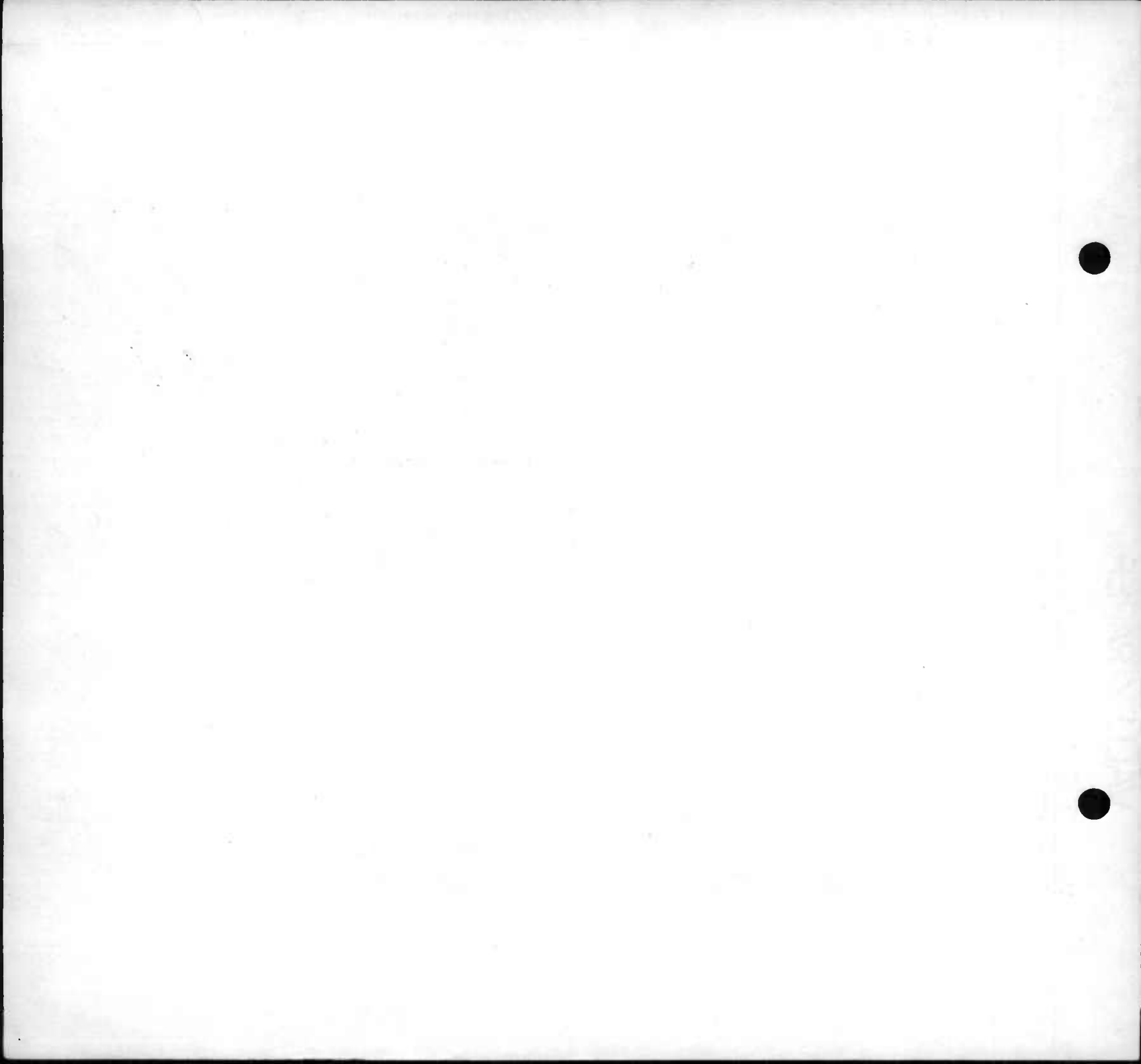
B-6550 BIRTH NO. 68-01706 68-1293				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 68-1293	
1. NAME OF DECEASED (Type or Print) <i>Baby Girl Brown</i>				2. DATE AND HOUR OF DEATH <i>1/26/68</i> <i>1968</i> <i>3:30</i> <i>A</i> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>42 Sinai Hospital of Baltimore, Inc.</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>MD</i>		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore Maryland</i>			
				D. STREET ADDRESS (If rural, give location) <i>1416 REGGS AVE</i>			
5. SEX <i>♀</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <i>1/25/68</i>	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>1</i>				14. MOTHER'S MAIDEN NAME <i>Brown, Ida grandmother</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Chart</i>		ADDRESS	
18. <i>762.2</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <i>Prematurity</i> (A) DUE TO <i>C-section Performed</i> (B) DUE TO <i>For eclampsia - 26 weeks</i> (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>767.5 II</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <i>Yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 25 1968</i> to <i>Jan 26 1968</i> , that (I) (we) last saw the deceased alive on <i>1:00 am Jan 26 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>J. Meyer Heller M.D.</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>J. Meyer Heller M.D.</i>				23D. ADDRESS <i>Sinai Hospital of Baltimore, Inc.</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <i>1-30-68</i>		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <i>FEB 2 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>		25C. FUNERAL DIRECTOR <i>UNIVERSITY MEDICAL SCHOOL HOSPITAL DISPOSAL</i>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 68-1294	
<div style="display: flex; justify-content: space-between;"> A-352 BIRTH NO. 68-02760 68-1294 CERTIFICATE OF DEATH </div>					
<div style="display: flex; justify-content: space-between;"> <div> M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Babu Boy "C" Adams </div> <div> 2. DATE AND HOUR OF DEATH 1/22/68 11:25 A.M. </div> </div>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <div style="display: flex;"> <div style="flex: 1;"> FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital of Baltimore </div> <div style="flex: 1; font-size: small;"> (If not in hospital or institution, give street address or location) </div> </div>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) <div style="display: flex;"> <div style="flex: 1;"> A. STATE Maryland </div> <div style="flex: 1;"> B. COUNTY 28-03 </div> </div> C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21216 D. STREET ADDRESS (If rural, give location) 4730 Wakefield Rd. Apt. 302		
5. SEX m	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) never married		8. DATE OF BIRTH 1/22/68	9. AGE (In years last birthday) 4 27
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		10B. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME Stelk.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT ADDRESS Hospital Records	
18. 776.1 I CAUSE OF DEATH <div style="display: flex;"> <div style="flex: 1;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="flex: 1;"> (A) DUE TO Massive Aspiration (B) DUE TO Hyaline Membrane Disease (C) Prematurity </div> <div style="flex: 1;"> INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours 4 30/60 4 1/2 </div> </div>					
773.5 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 3rd of Triplets					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) ✓	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/22/68 to 1/22/68, that (I) (we) last saw the deceased alive on 1/22/68 and that (n) (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Robert E. Farley</i>				23B. DATE SIGNED 1/22/68	
23C. PHYSICIAN'S NAME (Type) Alton J. Monfried		23D. ADDRESS Sinai Hospital of Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) 1-30-68		24C. NAME of CEMETERY or CREMATORY ANATOMY BOARD OF MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. FEB 2 1968		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR SCHOOL ADDRESS HOSPITAL DISPOSAL	



B-532

68-1295

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-1295

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

MARY BENTZ

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

9:15 a M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 2048 E. Federal St.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

9:15 a M.

January

17

1968

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

5-06

6. SEX

Female

7. RACE

White

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

10. AGE (In years
last birthday)
84If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

2048 E. FEDERAL ST.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

19.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

1-29-68

24C. NAME OF CEMETERY or CREMATORY

JOHNS HOPKINS MEDICAL SCHOOL

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

FEB 2 1968

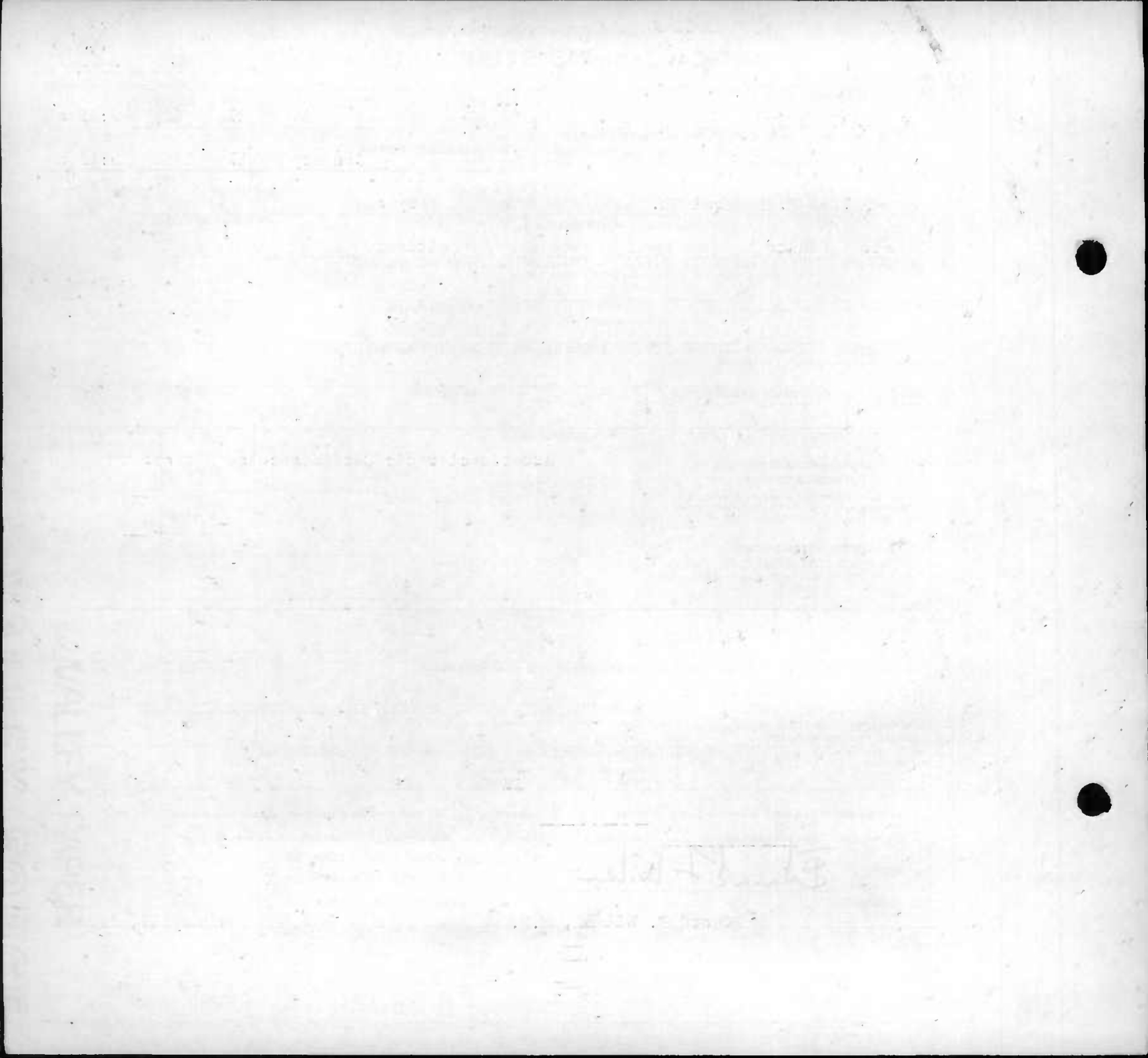
25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

ADDRESS

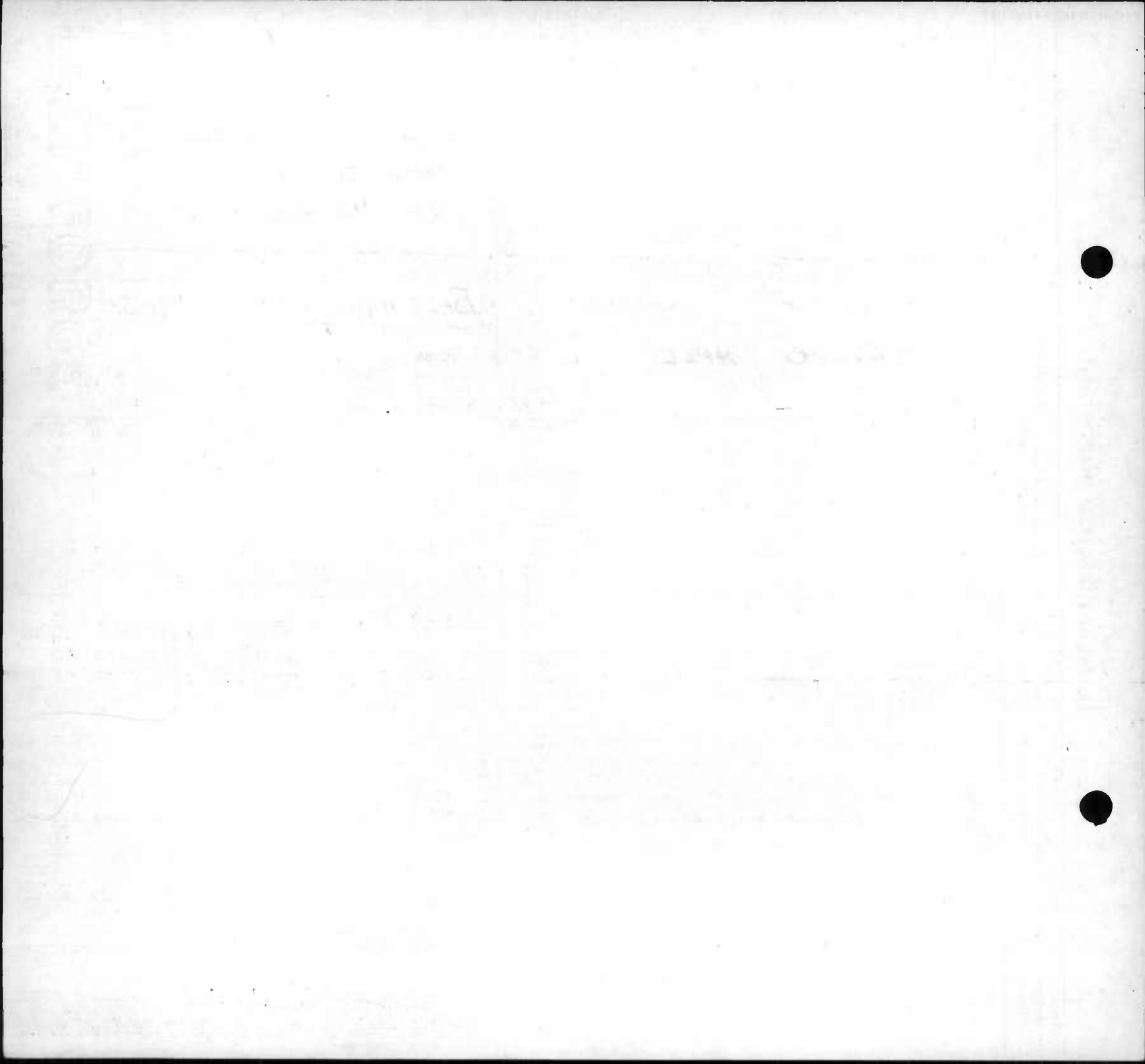
HOSPITAL DISPOSAL



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-400		68-1296		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1296	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Samuel Hall</i>			
2. DATE AND HOUR OF DEATH <i>1-30-68</i>				12 ⁵⁰ P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Mercy Hospital</i>				C. CITY OR TOWN <i>Essex (21)</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER <i>22 ORVILLE RD.</i>							
5. SEX <i>MALE</i>	6. RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-22-83</i>	9. AGE (In years last birthday) <i>84</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cabinet Maker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Wood Shop</i>		11. BIRTHPLACE (State or foreign country) <i>BALTIMORE, MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>TAYLOR HALL</i>				14. MOTHER'S MAIDEN NAME <i>Rose</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212 03 7664</i>		17. INFORMANT <i>William J. Hall</i>		ADDRESS <i>Same</i>	
18. <i>410.9+250.9</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary thrombosis</i> <i>atrial fibrillation</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>ASCVD old repeated infarcts</i> (C) <i>Diabetes Mellitus. pleuropneumonia</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <i>420.1</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>II</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>	
22. I certify that (I) (this hospital) attended the deceased from <i>1/30/68</i> to <i>1/30/68</i> , that (I) (we) lost saw the deceased alive on <i>1/30</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>A.H. Ghiladi</i>				23B. DATE SIGNED <i>1/30/68</i>			
23C. PHYSICIAN'S NAME (Type) <i>Abdelhamid Ghiladi</i>				23D. ADDRESS <i>Mercy Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>2/3/68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>FEB 2 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Prudzinski</i>		ADDRESS <i>Prudzinski Funeral Home 1407 Eastern Ave.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1297	
W-526 68-1297				BIRTH NO.	
1. NAME OF DECEASED (Type or Print) Katherine B. Wengert			2. DATE AND HOUR OF DEATH 1-31-1968 6:15 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD South Baltimore General Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Anne Arundel		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital			C. CITY OR TOWN Pasadena		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX F 6. RACE W			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 4, 1906
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress			10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 61
11. BIRTHPLACE (State or foreign country) Shippensburg, Pa.			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME John Laughery			14. MOTHER'S MAIDEN NAME Maude Wilson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 217-05-6438		17. INFORMANT Mr. Albert M. Wengert
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Cardiovascular disease			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C).....		
19. DATE OF OPERATION 4-20-1			20. A. AUTOPSY? (Yes or No) II		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Jan. 27, 1968 to Jan. 31, 1968		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) Jan. 31 1968			21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from Jan. 27, 1968 to Jan. 31, 1968 , that (I) (we) lost saw the deceased alive on Jan. 31 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			21F. HOW DID INJURY OCCUR? Jan. 31 1968		
23A. SIGNATURE William J. Mark MD			23B. DATE SIGNED 1-31-68		
23C. PHYSICIAN'S NAME (Type) William J. Mark MD			23D. ADDRESS 237 Patapsco Ave 21225		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 2/5/68		
24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial Park			24D. LOCATION (City, town, or county) (State) Glen Burnie, Md. A.A. Co.		
25A. DATE REC'D BY HEALTH DEPT. FEB 2 1968			25B. NAME OF REGISTRAR Robert E. Jackson		
25C. FUNERAL DIRECTOR McCully F. H.			25D. ADDRESS 237 Patapsco Ave 21225		

92129

South Island, New Zealand, 1962

X

F W

from 21 Jan 62 to 22 Feb 62

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

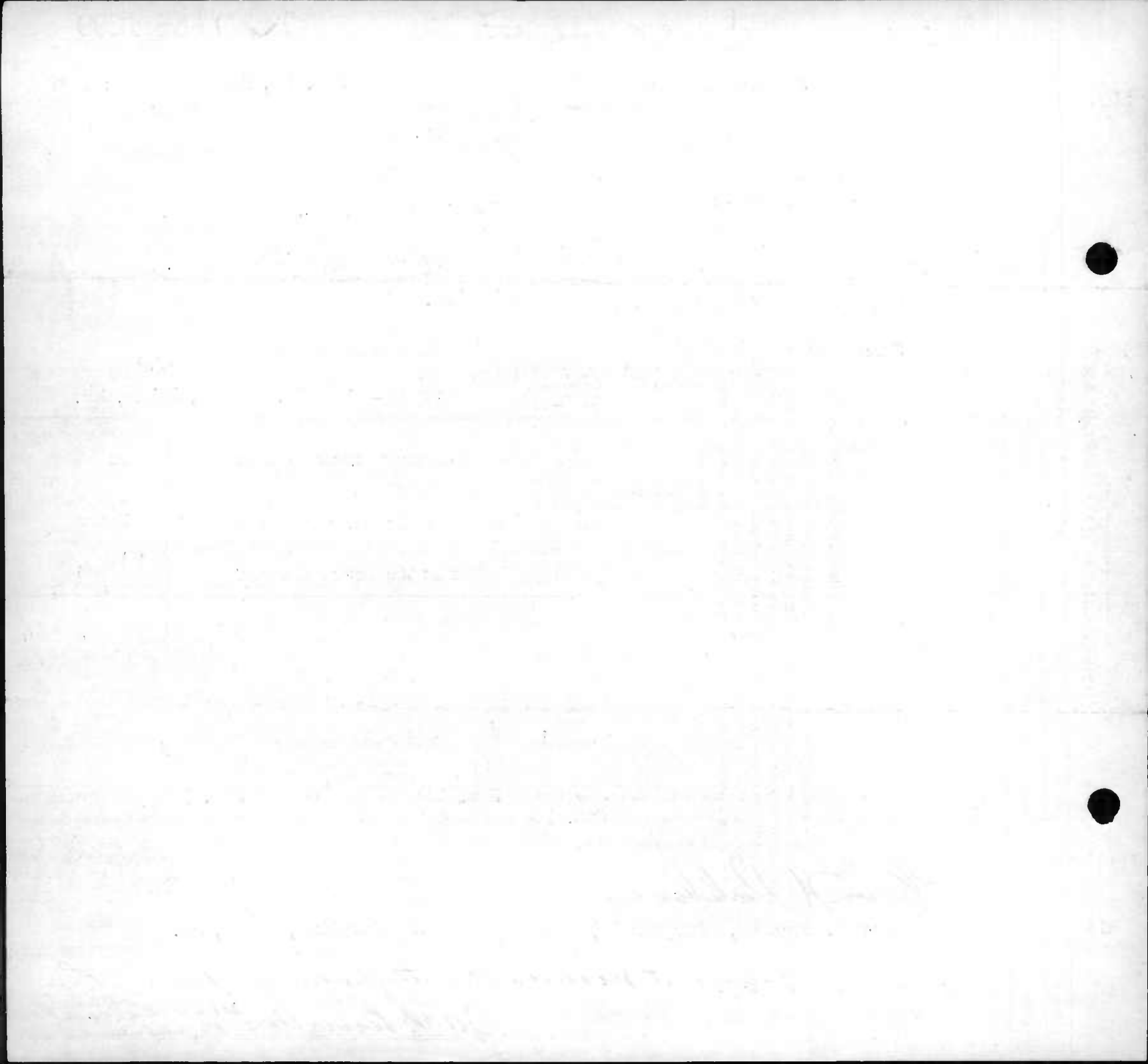
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 68- 1298	
BIRTH NO. <u>H-400</u>		68- 1298		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>OBEY L. HALL</u>		2. DATE AND HOUR OF DEATH <u>1-29-68</u> <u>8:33 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write rural and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>420 S. EATON ST. (24)</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>35 CHURCH HOME & HOSPITAL</u>		(If not in hospital or institution, give street address or location)			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>2-22-04</u>	9. AGE (In years last birthday) <u>63</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>STAND. CAP & MOLDING CO.</u>		11. BIRTHPLACE (State or foreign country) <u>TENNESSEE</u>	
13. FATHER'S NAME <u>SAM HALL</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-034961</u>		17. INFORMANT <u>WIFE 420 S. EATON ST. BALTO, 24, MD</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>250.9 I</u>		CAUSE OF DEATH (A) <u>Myocardial infarction</u> (B) <u>DIABETES MELLITUS +</u> (C) <u>infection @ foot</u>		INTERVAL BETWEEN ONSET AND DEATH <u>23 minutes</u>	
260X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>11-28-68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>infection @ foot</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1-25</u> 19 <u>68</u> to <u>1-29</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1-29</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Richard M. Theron</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1-30-68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. RAYMOND AT KINS</u>		23D. ADDRESS <u>CHURCH HOME & HOSP.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>2-1-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>SACRED HEART CEM.</u>	
24D. LOCATION <u>7401 GERMAN HILL RD. BALTO, CO., MD.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 2 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>		25C. FUNERAL DIRECTOR <u>Charles S. Zeiler</u>	
				ADDRESS <u>901 S. CONKLING ST. BALTO., 21224, MD.</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

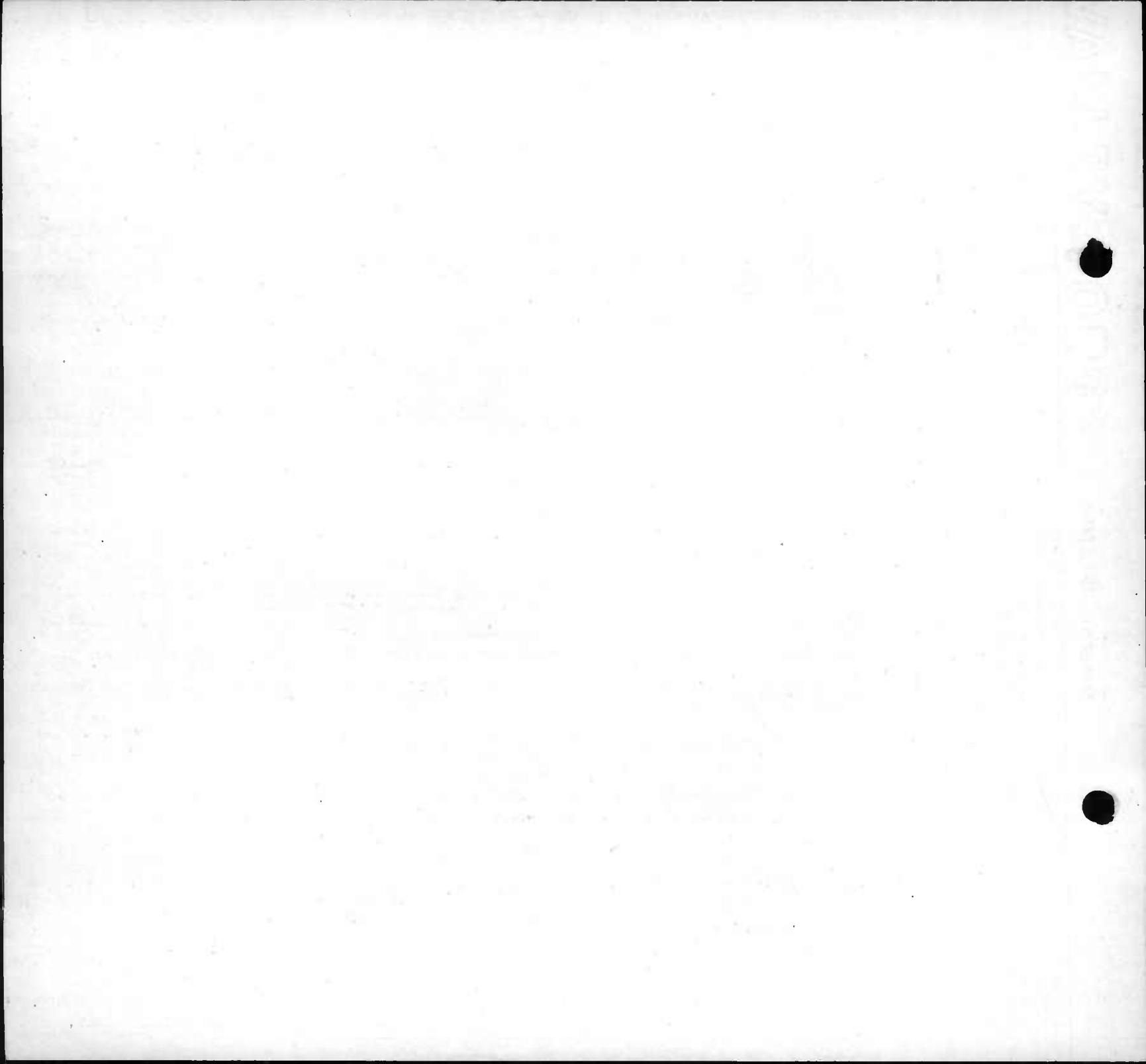
Baltimore City Health Department				REG. NO. 68-1299	
BIRTH NO. 68-1299				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Joannes Nicholas Bobuk			2. DATE AND HOUR OF DEATH Jan. 30, 1968 8:05 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 3100 Wyman Park Drive			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Pa. B. COUNTY C. CITY OR TOWN Duquesne D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1008 Lowrey St. V-35		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/6/21	9. AGE (In years last birthday) 46	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deck maintenance		10B. KIND OF BUSINESS OR INDUSTRY Seafarer	11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Bobuk			14. MOTHER'S MAIDEN NAME Elizabeth Buckiso		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 194-12-9507	17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.		
18. 398 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH Pulmonary edema & shock (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Multiple sequela due to (B) DUE TO, OR AS A CONSEQUENCE OF: Rheumatic heart disease (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours Years
MEDICAL CERTIFICATION 416 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan. 26 1968 to Jan. 30 1968, that (I) (we) last saw the deceased alive on Jan. 30 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Norman H. Peckham, Surgeon (R)			23B. DATE SIGNED 1/31/68		23C. PHYSICIAN'S NAME (Type) Norman H. Peckham, Surgeon (R)
24A. BURIAL CREMATION, REMOVAL (Specify) Removal			24B. DATE 2-6-68		24C. NAME OF CEMETERY or CREMATORY St. Nicholas Cemetery Duquesne, Pa.
25A. DATE REC'D BY HEALTH DEPT. FEB 2 1968			25B. NAME OF REGISTRAR Robert E. Jones		25C. FUNERAL DIRECTOR J. L. Lewis Inc 2100 East Ave Baltimore



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

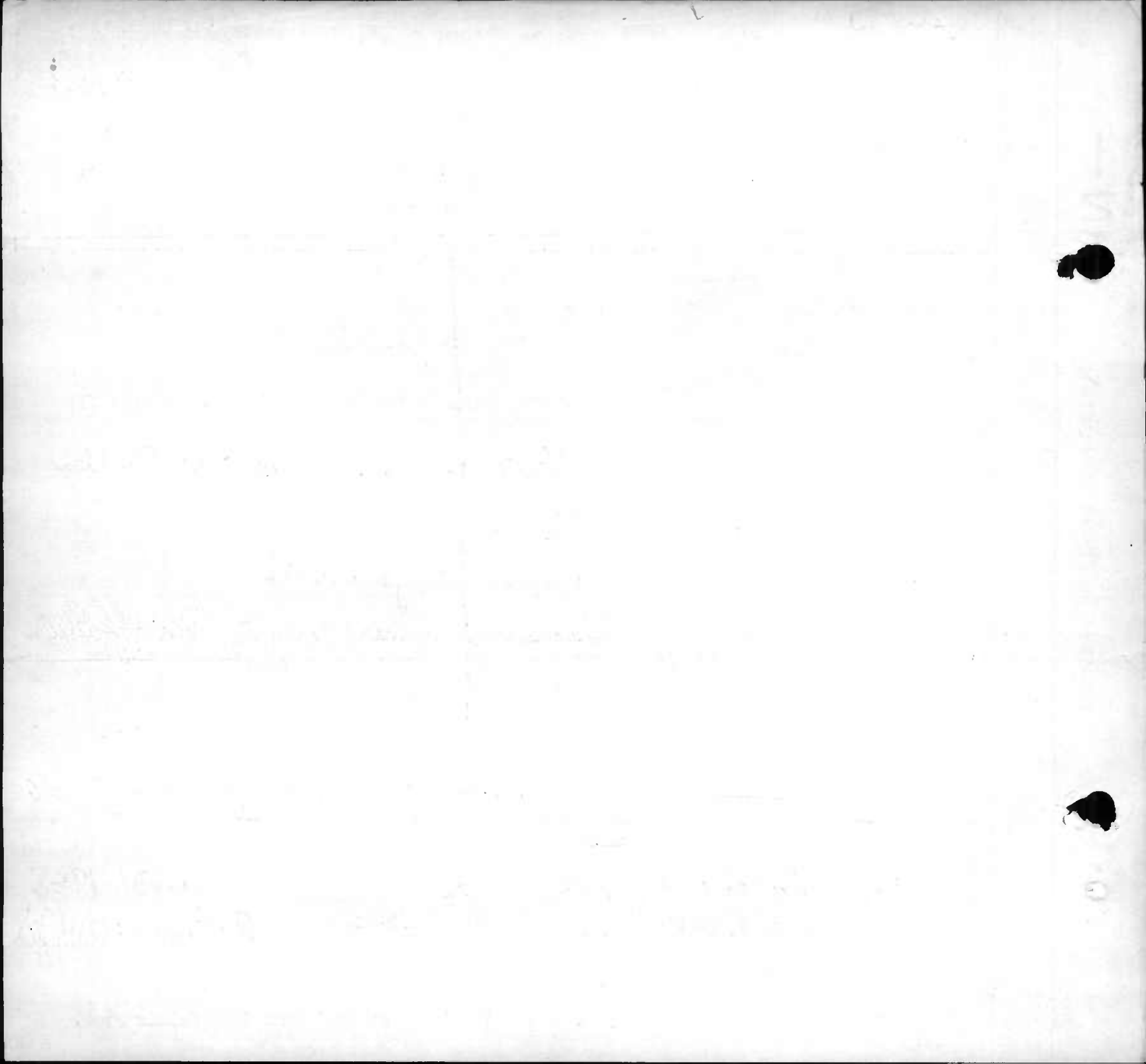
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1300	
BIRTH NO. H-622				68-1300	
1. NAME OF DECEASED (Type or Print) Conrad Herzog			2. DATE AND HOUR OF DEATH January 28, 1968 2:30 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 60 3119 McElderry St.,			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3119 McElderry St.,		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 10, 1895	9. AGE (In years lost birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Die maker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Stephen Herzog		14. MOTHER'S MAIDEN NAME Margaret Loos	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Marie Herzog, 3119 McElderry St., ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.9 I CORONARY OCCLUSION 2 minutes ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerosis, generalized > 10 years OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II Jaundice, chronic, obstructive, ampulla of Vater 6 months			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes-	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) yes.	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5 January 1968 to 28 Jan 1968, that (I) (we) last saw the deceased alive on 27 January 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Conrad Acton, M.D.				23B. DATE SIGNED 28 Jan 68	
23C. PHYSICIAN'S NAME (Type) Conrad Acton, M.D.				23D. ADDRESS 1208 St. Paul St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/31/68		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION Parkville, Md.		24E. DATE REC'D BY HEALTH DEPT. FEB 2 1968			
25A. NAME OF REGISTRAR Robert E. Taylor		25B. FUNERAL DIRECTOR Ullrich Funeral Home 4210 Belair Road.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1301	
<div style="text-align: center;"> <p>68-1301 CERTIFICATE OF DEATH</p> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)			
		George W. F. Poehlman			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH			
		January 29, 1968 9:40 P. M.			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
Gould Convalesarium		A. STATE Maryland B. COUNTY Balt			
		C. CITY OR TOWN Timonium		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER 207 Bfts Road			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Male	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Dec. 23, 1885	82	Merchant-retired
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Merchant-retired		Butter & Eggs		Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John Poehlman			Catherine Stout		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
No			217-01-5070 A		Mrs. Vivian Tenneman 3523 N. Calvert St.
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div> <p>18. 410.9 I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div> <p>(A) Immediate Cause</p> <p><i>Acute myocardial infarction</i></p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) <i>Coronary sclerosis</i></p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) <i>Chronic myocarditis</i></p> </div> <div> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p><i>Sudden</i></p> </div> </div>					
<div style="display: flex; justify-content: space-between;"> <div> <p>420.1 II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p> </div> <div> <p><i>Secondary anemia; congestive heart failure</i></p> </div> </div>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan. 21 1968 to January 29, 1968, that (I) (we) last saw the deceased alive on January 29, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<i>H.V. Harbold M.D.</i>				Jan. 31, 1968	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Harold V. Harbold, M.D.				4706 Harford Road, Baltimore 21214, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		2/1/68		Parkwood Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
FEB 2 1968		<i>Robert E. Taylor, M.D.</i>		Ullrich Funeral Home 4210 Belair Road.	



N-242 68-1302 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-1302

BIRTH NO.		1. NAME OF DECEASED (Type or Print) D. Nichols, Jr.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 1 31 1968 12:10 PM	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital D.O.A.		3. DATE PRONOUNCED DEAD Month Day Year Hour January 31 1968 12:10 PM		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 20-03	
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH May 20, 1940		10. AGE (In years lost birthday) 27		E. STREET AND NUMBER 621 So Pulaski St.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Lewis D. Nichols, Sr.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		14B. KIND OF BUSINESS OR INDUSTRY RESIDENTIAL		15. MOTHER'S MAIDEN NAME ELEANOR L. CAVEY FLORIE	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE		17. SOCIAL SECURITY NO. ?		18. INFORMANT ADDRESS ELEANOR CAVEY 621 S. PULASKI ST.	
19. 304.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 323X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH	
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Intravenous narcotism	
				(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) YES				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 2-3-68		24C. NAME OF CEMETERY or CREMATORY London Park	
24D. LOCATION (City, town, or county) (State) BALTIMORE, Md.		25A. DATE REC'D BY HEALTH DEPT. FEB 2 1968			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Geo. L. Schwab Funeral Home Francis H. Miller 2101 Frederick			

WILLIAMSON

WILLIAMSON

WILLIAMSON

68-1303

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-1303

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

SIMON R. EVANS

2. DATE AND HOUR OF DEATH

31 JANUARY 1968 8:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)BALTIMORE CITY HOSPITALS
49 40 EASTERN AVENUE
BALTIMORE MARYLAND 212244. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN
BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1624 E. EAGER ST.

21205

5. SEX

MALE

6. RACE

NEGRO

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

12-27-18

9. AGE (In years
last birthday)

49

If Under 1 Yr.

Months: Days

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

SOUTH CAROLINA

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

ROBERT

Evans

14. MOTHER'S MAIDEN NAME

VIRGINIA

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL

SECURITY NO.
251-12-3385

17. INFORMANT

RECORD, BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE BALTIMORE MD. 21224

ADDRESS

18. 151.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osthenio, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Carcinoma of stomach 4 months

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

151X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~the~~ (this hospital) attended the deceased from 27 NOVEMBER 1968 to 31 JANUARY 1968,
that ~~we~~ (we) last saw the deceased alive on 31 JANUARY 1968 and that in ~~the~~ (our) opinion death occurred on the date
and hour and from the causes stated above. (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE

Michael R. McMillan MD
MICHAEL McMILLANAttending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

1/31/68

23C. PHYSICIAN'S

MICHAEL McMILLAN

23D. ADDRESS

BALTIMORE CITY HOSPITALS
BALTIMORE MD.24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

Removal 2/2/68

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Jamestown S.C.

25A. DATE REC'D BY HEALTH DEPT.

FEB 2 1968

25B. NAME OF REGISTRAR

R. E. Evans

25C. FUNERAL DIRECTOR

M. E. Elickson 1297 Carroll St

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 13-210 68-1304				CITY HEALTH DEPARTMENT		REG. NO. 68-1304	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) William Bishop			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH 11/26/68 11:15 A.M.			
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1332 N. ELLWOOD AVENUE - 21213			
5. SEX Male		6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-15-10	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 57		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
13. FATHER'S NAME EARLY BISHOP (DEC'D)				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS: Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224	
18. 450X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: C H F (B) Multiple Pulmonary Emboli DUE TO, OR AS A CONSEQUENCE OF: (C)			
19. 423X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/15 1967 to 1/26 1968, that (I) (we) lost s/he the deceased on 1/26 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE M. Jaffe				23B. DATE SIGNED 11/26/68			
23C. PHYSICIAN'S NAME (Type) M. Jaffe				23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan 31/68		24C. NAME OF CEMETERY OR CREMATORY Arboretum Mem Park		24D. LOCATION (City, town, or county) (State) Cibola, Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 2 1968		25B. NAME OF REGISTRAR C. E. Fellers		25C. FUNERAL DIRECTOR Milton E. Elchman		ADDRESS 1129 N. Carroll St	

01-21 E

11 11

7 H 3

100 percent 1/2 pt 100

100

100

100

100

100

100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

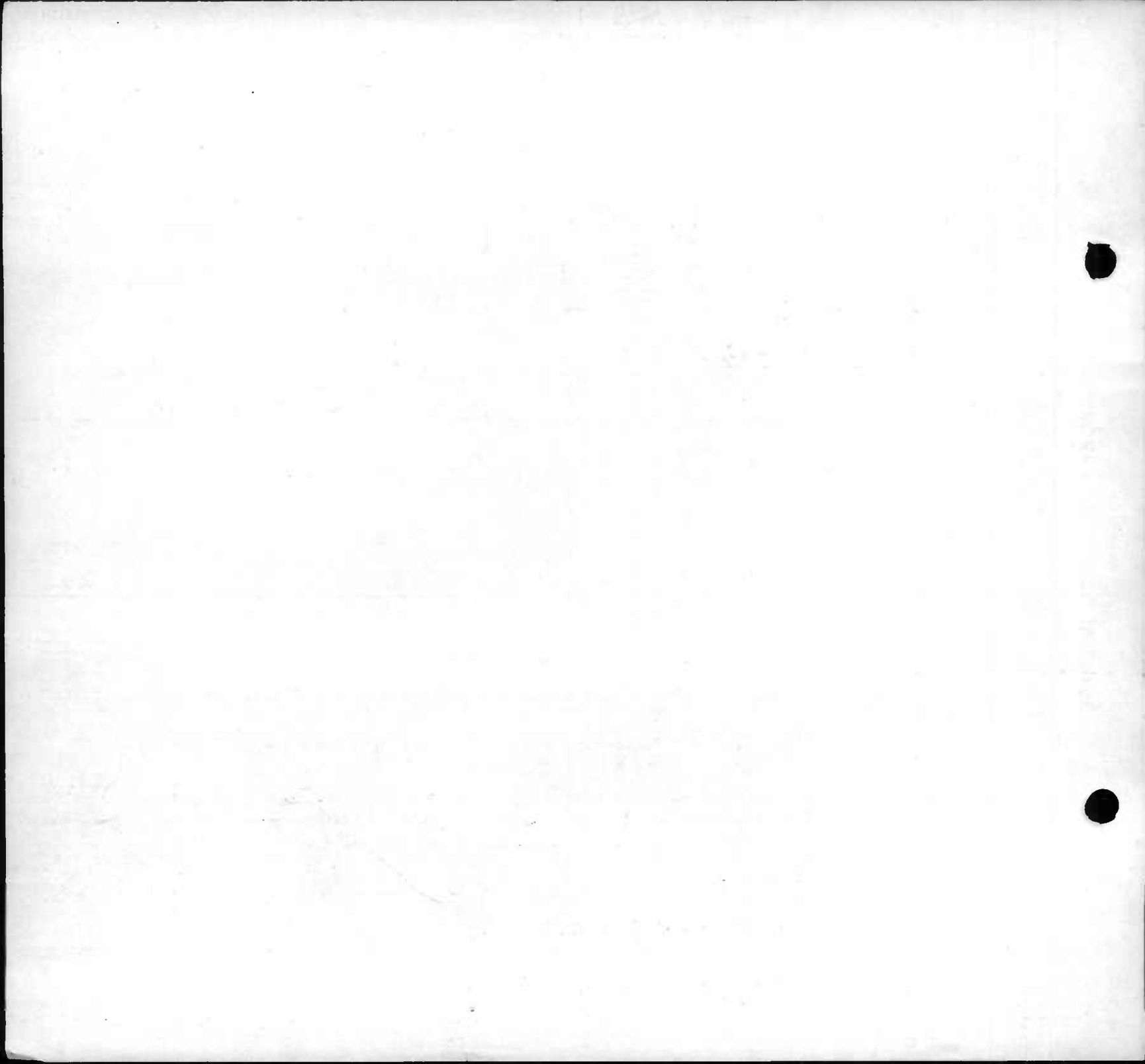
68-1305

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-1305

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Annie Curtis</i>		2. DATE AND HOUR OF DEATH <i>January 24 1968</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>5-02</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>200 Acquith St. Apt 4</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER					
5. SEX <i>Female</i>	6. RACE <i>Chad</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 15 1886</i>	9. AGE (In years last birthday) <i>81</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Berkley Va.</i>	
13. FATHER'S NAME <i>John Morris</i>		14. MOTHER'S MAIDEN NAME <i>Martha?</i>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Arthur Harry 1627 Payson St</i> ADDRESS	
18. <i>412.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary Artery Disease</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>422.1 II</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3 24 68</i> 19 <i>68</i> to <i>1-24</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>1-10</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>William D. Watt</i>		23B. DATE SIGNED <i>1/29/68</i>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <i>William D. Watt</i>		23D. ADDRESS <i>515 N. Arlington Ave</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Jan 26 1968</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Arbutus New Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Arbutus, Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>FEB 2 1968</i>		25B. NAME OF REGISTRAR <i>R. E. E. Johnson</i>	
25C. FUNERAL DIRECTOR <i>John E. Johnson</i>		ADDRESS <i>1129 N. Eastland</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
BIRTH NO.		<div style="text-align: right;">REG. NO. 68-1306</div>							
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH							
Cleary, Anita		1/27/68 11:45 P. M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION					A. STATE				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					B. COUNTY				
THE JOHNS HOPKINS HOSPITAL					MARYLAND				
33 601 N. BROADWAY					C. CITY OR TOWN				
BALTIMORE, MARYLAND 21205					BALTIMORE CITY				
					D. INSIDE CITY LIMITS?				
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
					E. STREET AND NUMBER				
					1600 E. BIDDLE STREET				
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		If Under 1 Yr. Months Days	
FEMALE	NEGROID	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7/12/07		66 YRS.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Housewife				Philadelphia, Pa.			U.S.A.		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
HENDRICKSON, FRANK				HARDLEY, HENRIETTA					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No						William Cleary - 1600 E. Biddle			
18. 4129 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Congestive Heart Failure					
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				ASCD					
				(B) DUE TO, OR AS A CONSEQUENCE OF:					
				(C) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
422.1 II									
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		(Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (if this hospital) attended the deceased from January 25 1968 to January 27 1968, that (if we) last saw the deceased alive on January 27 1968 and that in my opinion death occurred on the date and hour and from the causes stated above, (if we) (did) (did not) view the body after death.									
23A. SIGNATURE						23B. DATE SIGNED			
John T. Flaherty M.D.						1/27/68			
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS			
JOHN T. FLAHERTY, M.D.						JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		Feb 1/68		Mt. Calvary Cem.		Ad. County Md			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
FEB 2 1968		R. E. E. Johnson		Z. E. E. Johnson		129 N. Calhoun			

1
m-245

68-1307

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-1307

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

EURALEA MC CLINTON

2. DATE
OF
DEATH

Known ☒ Estimated ☐

Month

Day

Year

Hour

January 28, 1968

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Sinai Hospital

(DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

January 28, 1968

7:50 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

6. SEX

Female

7. RACE

Negro

8. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

9. DATE OF BIRTH

Sept 2, 1933

10. AGE (In years
last birthday)

34

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

119 S. Exeter Street

11. BIRTHPLACE (State or foreign country)

Bal & Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Carl Fleming

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Grace Johnson

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Marys McClinton, 19 S. Exeter St

19.

412.0 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Hypertensive cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

443 X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐

NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

Charles S. Springate

M.D.

EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 29, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

Feb 2/68

24C. NAME of CEMETERY or CREMATORY

Mt Auburn Cem

24D. LOCATION (City, town, or county) (State)

Westport Md

25A. DATE REC'D BY HEALTH DEPT.

FEB 2 1968

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Milton E. Elckson 1129 N. Caroline

ADDRESS

Handwritten text, possibly a signature or address, located in the upper middle section of the page.

Small line of text, possibly a date or reference number, located below the main handwritten block.

WALTER BROWN

WALTER BROWN

Handwritten text at the bottom of the page, possibly a signature or address.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1308	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MARY FERGUSON		2. DATE AND HOUR OF DEATH January 23, 1968 9:50 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE, MARYLAND D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1436 E. MONUMENT ST.	
5. SEX NEGRO FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-15-07	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY N.C.		11. BIRTHPLACE (State or foreign country) N.C.	
13. FATHER'S NAME ALONZO FERGUSON			14. MOTHER'S MAIDEN NAME LUCY WILLIAMS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Records	
18. 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Renal Failure & Uremia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Diabetes Mellitus (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION 260X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work 21F. HOW DID INJURY OCCUR?					
22. I certify that (X) (this hospital) attended the deceased from January 8, 1968 to January 23, 1968, that (X) (we) last saw the deceased alive on January 23, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John F. Flaherty MD DEGREE				23B. DATE/SIGNED 1/23/68 Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) JOHN F. FLAHERTY DEGREE				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan 29/68		24C. NAME of CEMETERY or CREMATORY Mt Auburn Cem	
24D. LOCATION (City, town, or county) (State) Westport, Md.		25A. DATE REC'D BY HEALTH DEPT. FEB 2 1968		25B. NAME OF REGISTRAR Robert E. Farley	
25C. FUNERAL DIRECTOR Milton E. Elkins		25D. ADDRESS 1129 N. Calver St			

IT

IT

IT

Yes

IT

IT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1309

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-1309

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

PAULINE HAYES

2. DATE AND HOUR OF DEATH

Jan 30th 1968 4-00 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)46 Lutheran hospital
Baltimore 21216

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

md

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

2844 Rayner Ave

5. SEX

Female

6. RACE

coloured

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

11-29-'94

9. AGE (In years
last birthday)

73

If Under 1 Yr.
Months: DaysIf Under 24 Hrs.
Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

South carolina

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Sankuconstant

14. MOTHER'S MAIDEN NAME

Nancy

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

-

16. SOCIAL
SECURITY NO.

17. INFORMANT

Ruth Hayes
Daughter

ADDRESS

2844 Rayner
566-3463 ans

18.

486X I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

meningitis

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Pneumonia

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH4
6 weeks

MEDICAL CERTIFICATION

493X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED20A. AUTOPSY? ☒ or Not20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

No

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (he) (this hospital) attended the deceased from 1-5-1968 to 1-30-1968,
that (he) (we) last saw the deceased alive on 1-30-1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

BIPIN A. DESAI

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

Jan 30th 196823C. PHYSICIAN'S
NAME (Type)

BIPIN A. DESAI

23D. ADDRESS

96 Lutheran hospital

24A. BURIAL CREMATION,
REMOVAL (Specify)

Removal 1-31-68

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

Nazarene

24D. LOCATION

(City, town, or county)

Mullan

(State)

S.C.

25A. DATE REC'D BY HEALTH DEPT.

FEB 2 1968

25B. NAME OF REGISTRAR

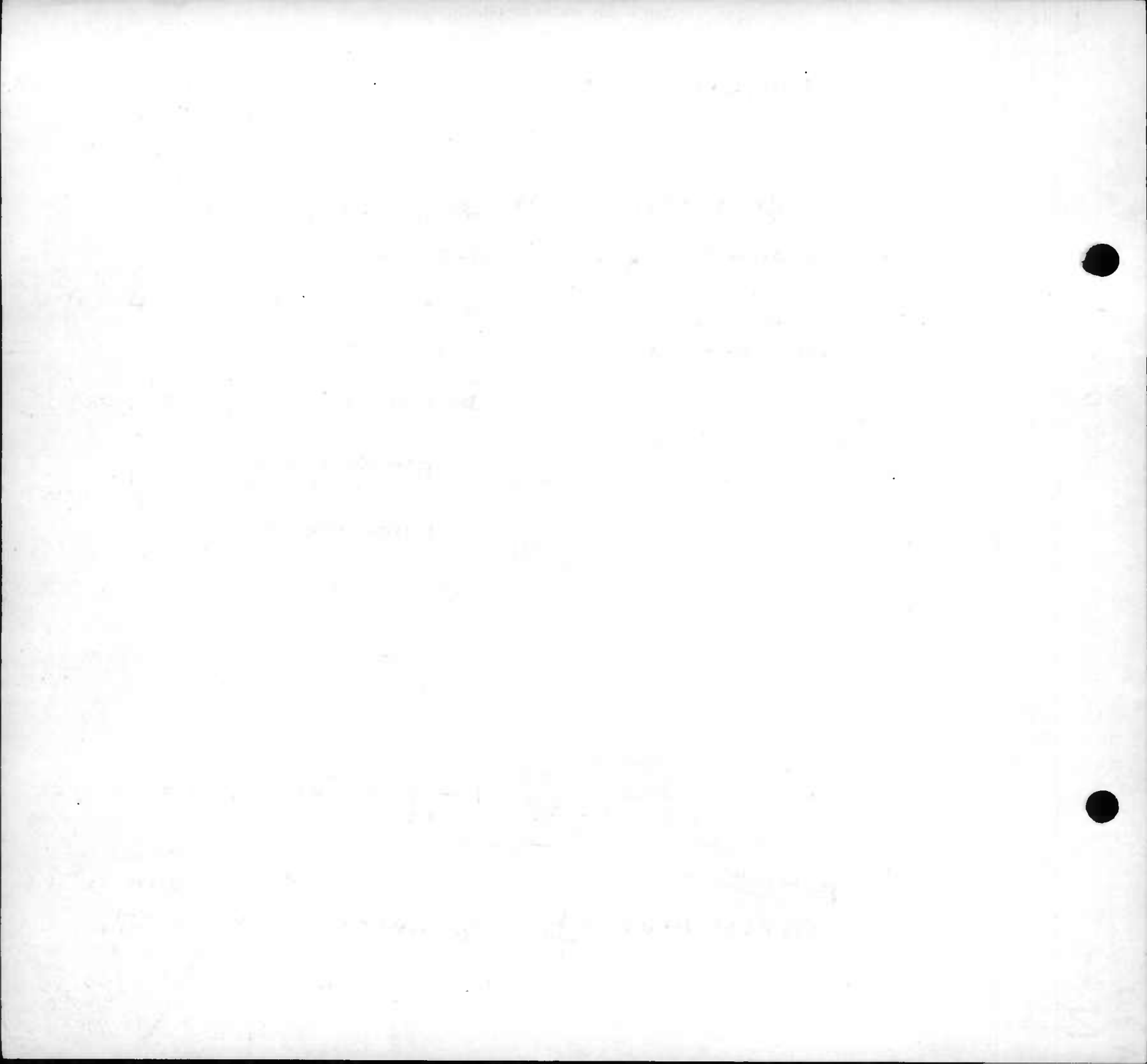
Robert E. Taylor

25C. FUNERAL DIRECTOR

Phillips (Horn)

ADDRESS

4727



FUNERAL DIRECTOR: IMPORTANT

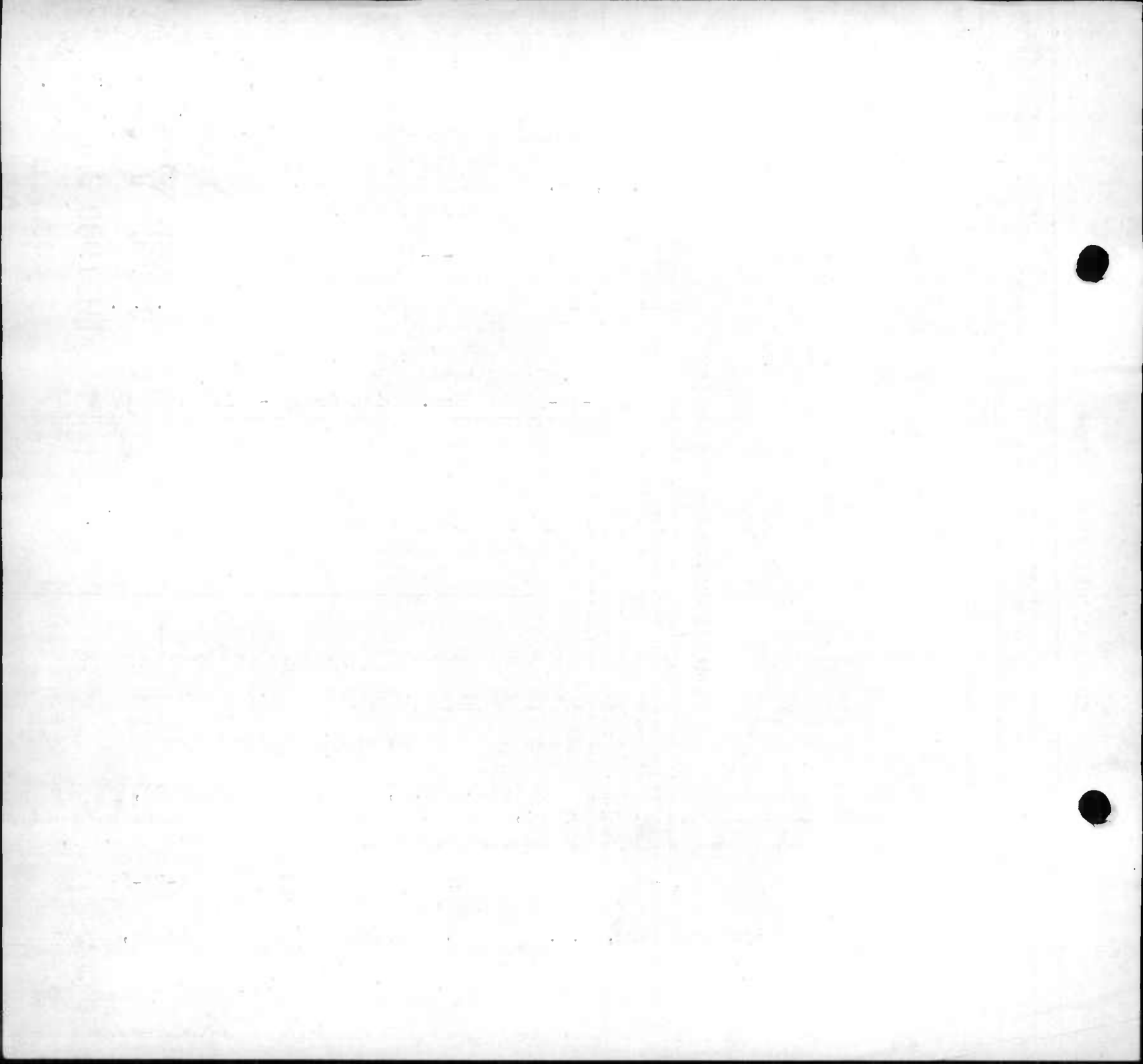
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1310

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 1310

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Walter Grady		2. DATE AND HOUR OF DEATH January 28, 1968 6:15 A.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Armco Steel		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME William Grady		14. MOTHER'S MAIDEN NAME Pearl		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 722-48-5952		17. INFORMANT Mrs. Edith Grady - Wife	
18. 412.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 443X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MIEMIA (B) HELD to congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks 2 yrs	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Nat White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from December 28, 1967 to January 28, 1968 , that (I) (we) last saw the deceased alive on January 28, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Elijah Saunders				23B. DATE SIGNED 1-29-69	
23C. PHYSICIAN'S NAME (Type) Elijah Saunders, M.D.				23D. ADDRESS 3414 Duval Avenue Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-1-68		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	
24D. LOCATION (City, town, or county) (State) MD		25A. DATE REC'D BY HEALTH DEPT. FEB 2 1968			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR William J. Phillips			
25D. ADDRESS		1727 N. Maryland			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-1311</u>
W-300		68-1311		CERTIFICATE OF DEATH
BIRTH NO.		2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>James White</u>		2/1/68 8:30 P.M. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if in institution, residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE <u>Maryland</u>		
<u>Lincoln Memorial Nursing Home</u> <u>Baltimore, Maryland</u>		B. COUNTY <u>14-03</u>		
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>1820 Madison Avenue</u>		
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/10/02</u>	9. AGE (In years last birthday) <u>65</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>227-10-1236</u>		17. INFORMANT <u>Mary Robinson</u> ADDRESS <u>1316 Carey St.</u>
18. <u>1579</u> I <u>1</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE <u>Carcinoma of the Pancreas</u>		
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES		(B) _____		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____		
19. DATE OF OPERATION <u>157X</u> II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>1/31</u> 19 <u>68</u> to <u>2/1</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2/1</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>2/1/68</u>		
23C. PHYSICIAN'S NAME (Type) <u>Harris</u>		23D. ADDRESS <u>2519 KENNISSED AV BALTO.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>2-5-68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>
24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 2 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Kelson Funeral Home</u> ADDRESS <u>1348 Calhoun St.</u>

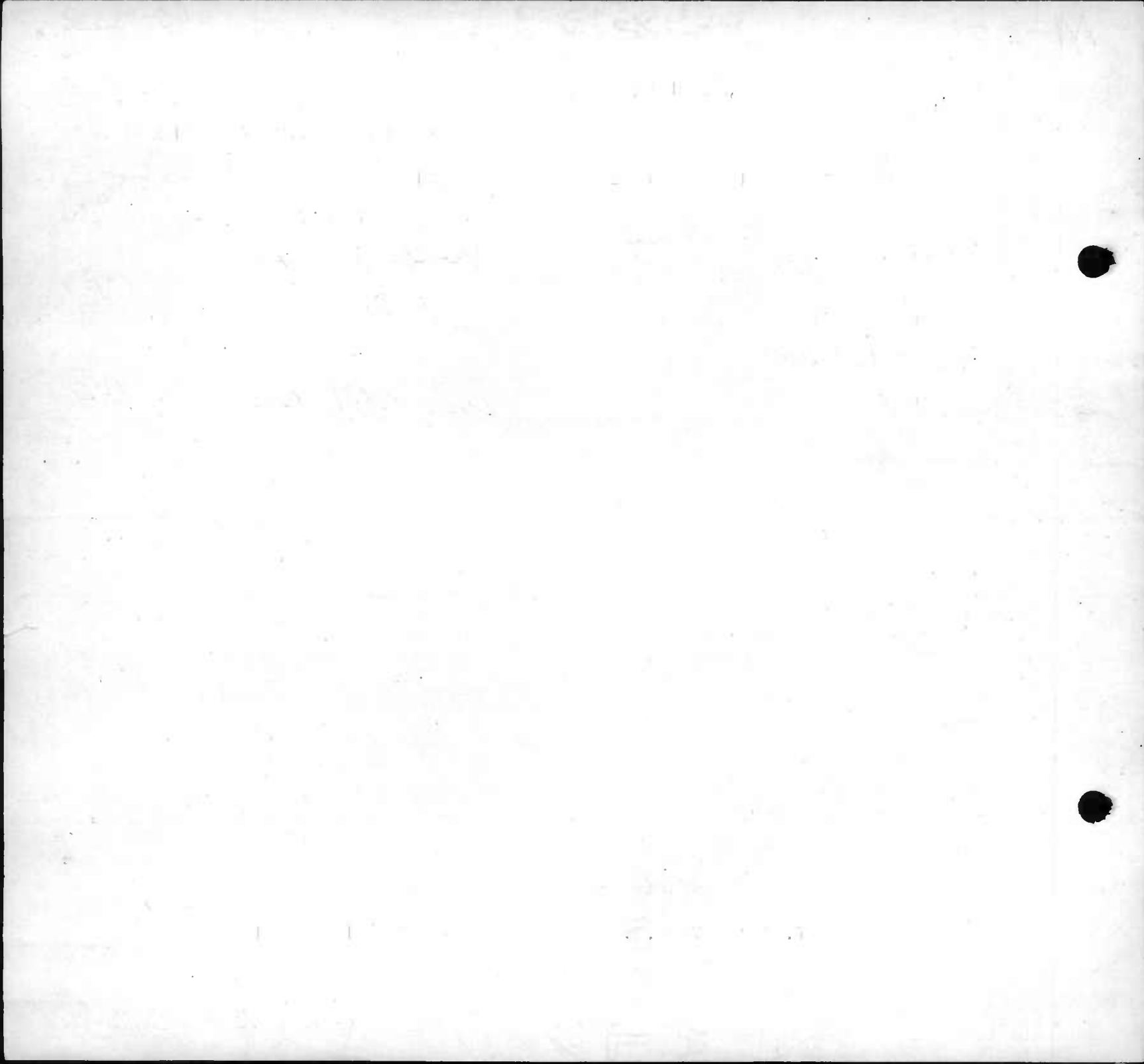
James
George
James

22nd November

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 1312	
68- 1312				BIRTH NO.	
1. NAME OF DECEASED (Type or Print) MUSE, LUCILLE			2. DATE AND HOUR OF DEATH 1/31/68 4³⁰ M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY CITY OF BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1833 NORTH PATTERSON PARK AVENUE		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-18-19	9. AGE (In years last birthday) 48	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundress		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N. C.	
13. FATHER'S NAME CHARLES JAMES			14. MOTHER'S MAIDEN NAME BETTY GREENE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Bessie Roberts 1612 Danley St AP	
18. 2014X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Prob. Intra peritoneal Tuberculosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Severe progressive Carcinosis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from November 24 1968 to January 31 1968 , that (1) (we) last saw the deceased alive on January 31 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John T. Flaherty				23B. DATE SIGNED 1/31/68	
23C. PHYSICIAN'S NAME (Type) JOHN T. FLAHERTY M.D.				23D. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/3/68		24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary	
24D. LOCATION (City, town, or county) (State) D. D. County, Md		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR Robert E. Isely		25C. FUNERAL DIRECTOR Joseph B. Lockhart 1304X Central AP			

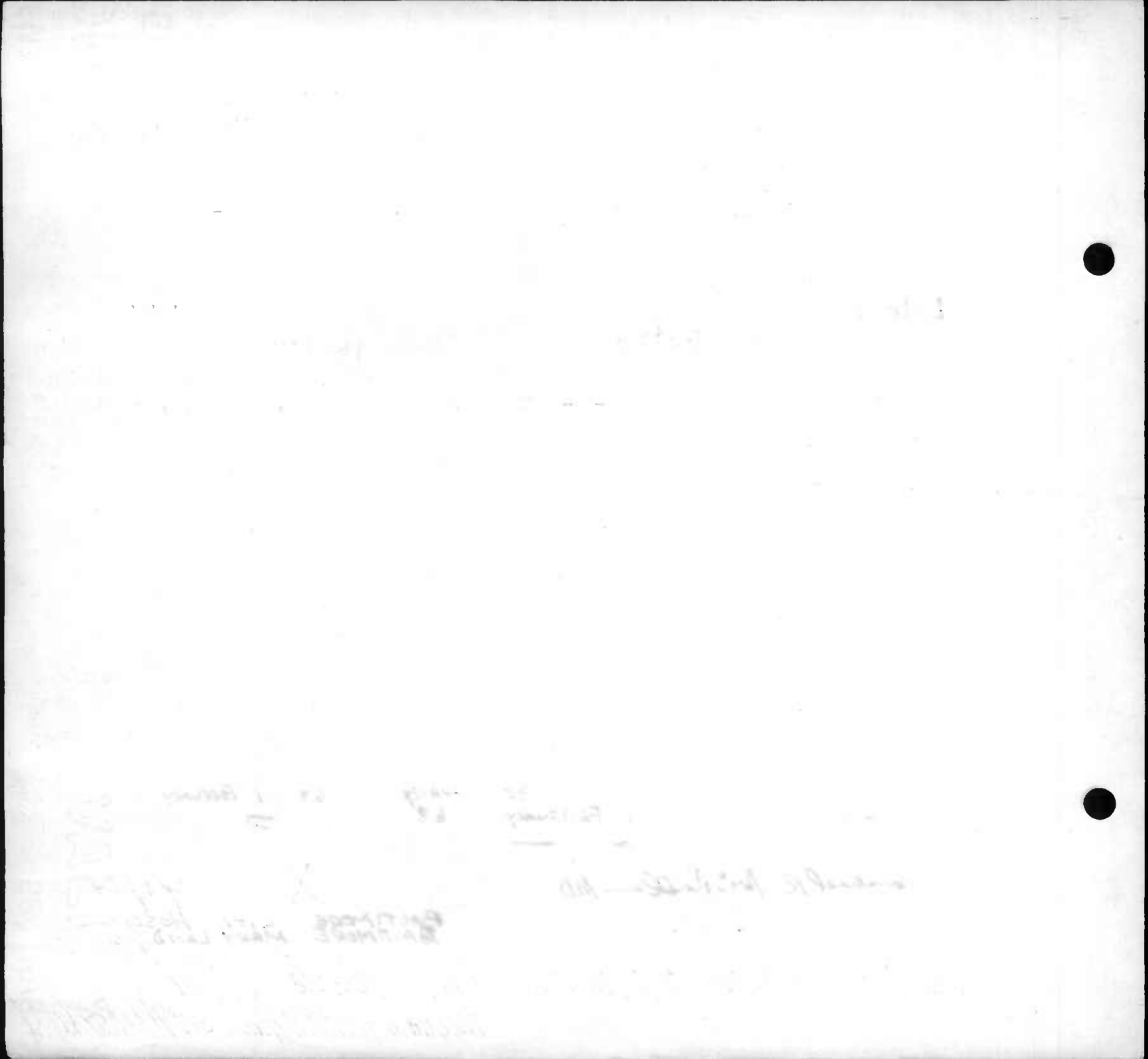


51-05-35 1
IW

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-340 68-1313		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1313	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) HAYWOOD BATTLE		2. DATE AND HOUR OF DEATH 1 FEBRUARY 1968 12:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 18-02		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		6. RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 5/3/00		9. AGE (In years last birthday) 67		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME COLUMBUS Battle		14. MOTHER'S MAIDEN NAME MINNIE Proctor	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-03-4217A		17. INFORMANT RECORDS: Baltimore City Hospitals 21224 4940 Eastern Avenue, Baltimore, Maryland	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 185X I Carcinoma of Prostate 3 months		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 177X II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Widespread metastases from above		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (the hospital) attended the deceased from 30 JANUARY 1968 to 1 FEBRUARY 1968 , that (I) we last saw the deceased alive on 1 FEBRUARY 1968 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we (did) (didn't) view the body after death.			
23A. SIGNATURE Michael R. McMillan MD		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 2/1/68	
23C. PHYSICIAN'S NAME (Type) Michael R. McMillan		23D. ADDRESS 4940 Eastern Avenue BALTIMORE CITY HOSPITALS BALTIMORE MARYLAND 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/3/68		24C. NAME OF CEMETERY or CREMATORY McMillan	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. FEB 2 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Williams Funeral Home		25D. ADDRESS 3199 Schuyler St			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 1314 CERTIFICATE OF DEATH

REG. NO. 68- 1314

BIRTH NO.		1. NAME OF DECEASED (Type or Print) GOODMAN, Frank NMI		2. DATE AND HOUR OF DEATH 1-27-68 12:40 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 19-02		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		E. STREET AND NUMBER 1413 W. Fayette St.			
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-4-97	9. AGE (In years lost birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME George Goodman		14. MOTHER'S MAIDEN NAME Mary Venie	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 10-26-17 to 7-9-19		16. SOCIAL SECURITY NO. 218-01-21-48		17. INFORMANT Records ADDRESS VAH, Balto., Md 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 162-1 I Carcinoma of left lung with extensive regional involvement to ribs, pericardium and myocardium		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17 months	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		163X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Pulmonary embolus to Right Lower Lobe			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that NO (this hospital) attended the deceased from December 6, 1967 to January 27, 1968 , that (X) (we) last saw the deceased alive on January 27, 1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. NO (We) (did) NOT view the body after death.					
23A. SIGNATURE Joseph Silva, M.D.		23B. DATE SIGNED 1/31/68		23C. PHYSICIAN'S NAME (Type) DEGREE	
23D. ADDRESS Veterans Administration Hospital 3900 Loch Raven Blvd., Baltimore, Md. 21218		23E. DATE RECEIVED BY HEALTH DEPT. Feb 2 1968		23F. NAME OF REGISTRAR Reuben E. Fawcett	
23G. DATE RECEIVED BY HEALTH DEPT. Feb 2 1968		23H. NAME OF REGISTRAR Reuben E. Fawcett		23I. FUNERAL DIRECTOR Williams Funeral Home 3197 Schroeder St.	

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1 to 1-1-1

1-1-1

1-1-1

1-1-1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1315

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 1315

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JACKSON, EFFIE INEZ

2. DATE AND HOUR OF DEATH

1/27/68

8-45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

LUTHERAN
HOSPITAL
OF MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

DUKELAND ST. 1501 - N.

5. SEX

FEMALE

6. RACE

COLOURED

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

3/30/1891

9. AGE (In years
last birthday)

76 YRS.

If Under 1 Yr.
Months: Days

If Under 24 Hrs.
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Scott

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Regina Campbell 2119 Chilton Ave.

18.

486X I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Respiratory Failure

(B) Pneumonia & chronic brain
DUE TO, OR AS A CONSEQUENCE OF:

(C) Syndrome

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

493X II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

21D. TIME
OF INJURY
(APPROX.)

While At
Work ☐

Not While
At Work ☐

22. I certify that (I) (this hospital) attended the deceased from 1/10/68 19 to 1/27/68 19
that (I) ~~last~~ saw the deceased alive on 1/27/68 19 and that in (my) ~~our~~ opinion death occurred on the date
and hour and from the causes stated above. (I) ~~was~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE

P. P. Joshi

M.D.

Attending
Phys. ☐

Med.
Director ☐

Staff
Phys. ☒

23B. DATE SIGNED

1/27/68

23C. PHYSICIAN'S
NAME (Type)

P. P. JOSHI

MD

23D. ADDRESS

730 ASHBURTON ST. BALTIMORE

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1/31/68

24C. NAME OF CEMETERY or CREMATORY

Arbutus Memorial Park

24D. LOCATION

Arbutus (Baltimore) Md.

25A. DATE REC'D BY HEALTH DEPT.

FEB 2 1968

25B. NAME OF REGISTRAR

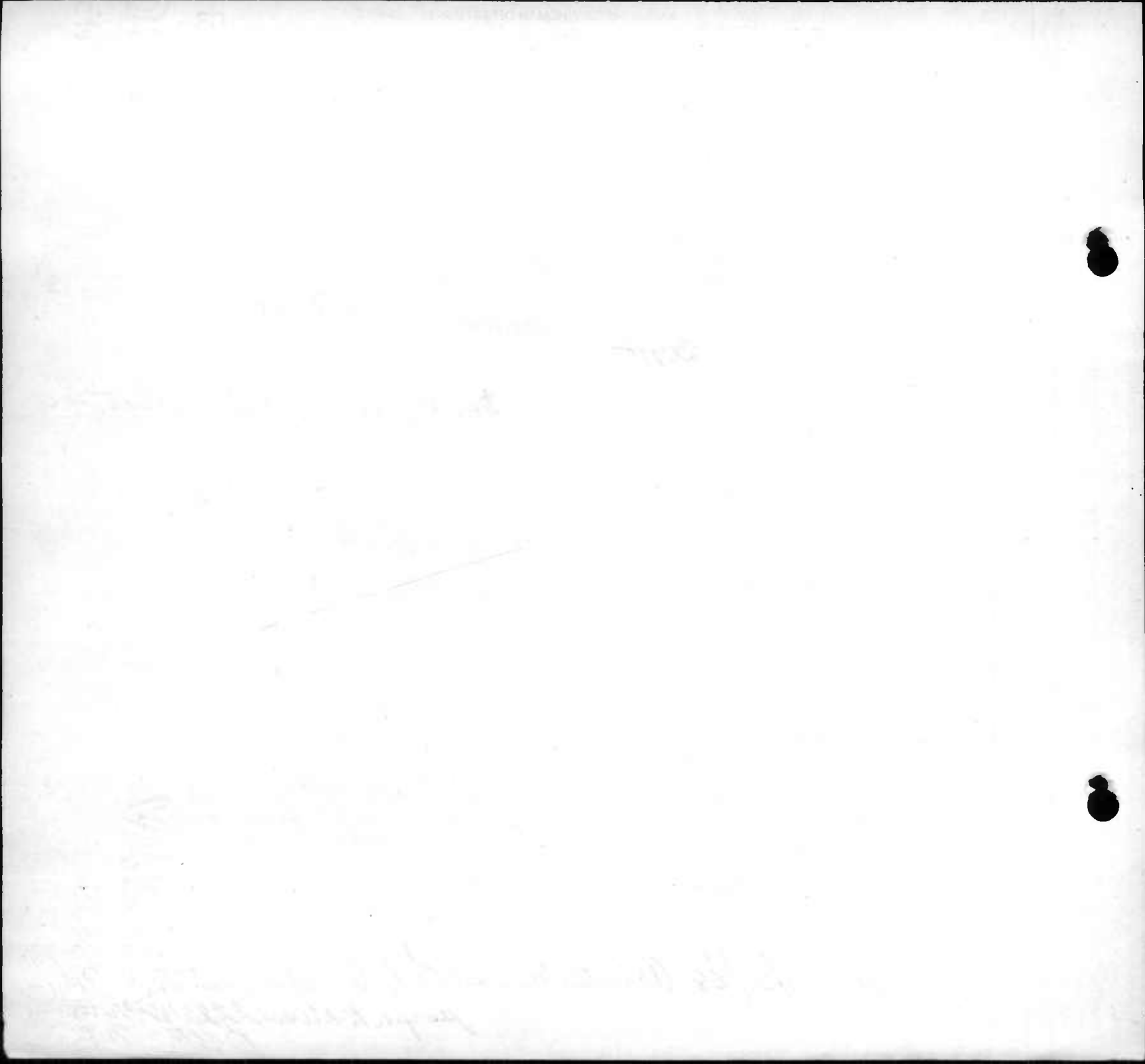
Robert E. Taylor, MD

25C. FUNERAL DIRECTOR

Joseph L. Russ 2222 W. North Ave.

ADDRESS

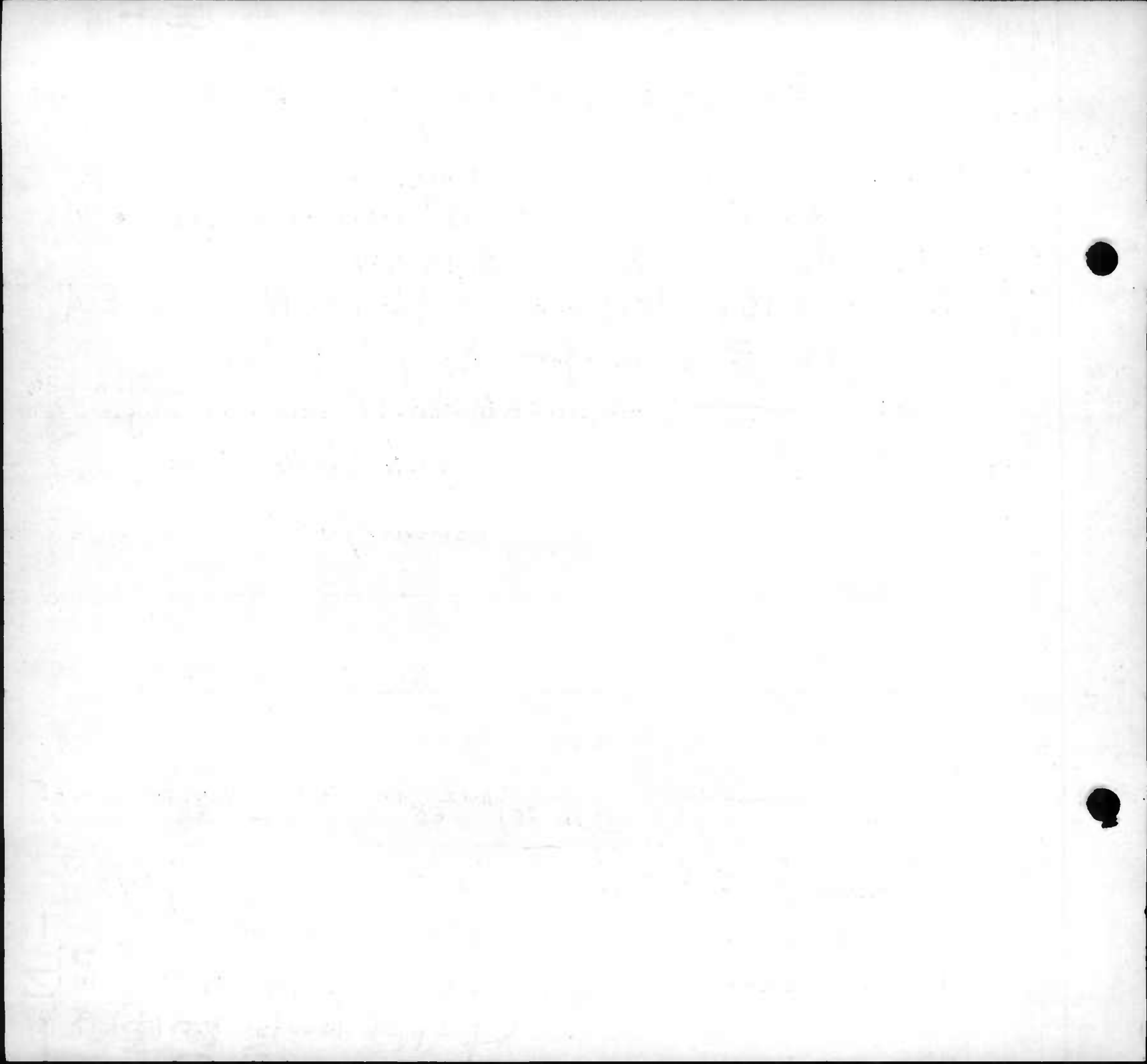
Baltimore, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 68-1316	
BIRTH NO. 68-1316				1. NAME OF DECEASED (Type or Print) <u>George H. Schaefer</u>		2. DATE AND HOUR OF DEATH <u>Jan 30-68 11:20 AM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Holly Hill Nursing Home</u> <u>531 Stevenson Lane</u>				A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u>			
				C. CITY OR TOWN <u>Kingsville</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <u>Goettner Rd. Kingsville Md</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 4 1981</u>		9. AGE (In years last birthday) <u>86</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Millworker Beth. Steel</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Louis F. Schaefer</u>				14. MOTHER'S MAIDEN NAME <u>Mary Schuler</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>213091105A</u>		17. INFORMANT <u>Michael F. Schaefer</u> ADDRESS <u>Goettner Rd Kingsville Md</u>	
18. <u>440.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Cardiac Failure</u>			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerosis</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) _____			
19. <u>450.0 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>June 12 1967</u> to <u>Jan. 30 1968</u> , that (I) (we) last saw the deceased alive on <u>Jan 30 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Laurence C. Post M.D.</u>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>1/31/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>LAURENCE C. POST</u>				23D. ADDRESS <u>6805 YORK ROAD</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>2-2-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Moneland Park</u>		24D. LOCATION (City, town, or county) (State) <u>Taylor Ave Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 2 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Dippel Bros. Inc.</u>		ADDRESS <u>7110 Belair Rd</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-420		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1317	
BIRTH NO.		68-1317		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Celich MRS Mary		2. DATE AND HOUR OF DEATH 30th JAN 1968 11-55 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 35 CHURCH HOME AND HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 CHURCH HOME AND HOSPITAL		C. CITY OR TOWN BALTIMORE 21202		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 127 S. EXETER ST 3-02			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-13-1893	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME MAKER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) YUGOSLAVIA	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Nicholas Radanovich		14. MOTHER'S MAIDEN NAME Not Known	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-14-8827A		17. INFORMANT Mr. Stephen Celich (son) 1717 E. Fairmount Ave. Baltimore Md	
18. 492 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CONGESTIVE FAILURE		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF CONGESTIVE FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. EMPHYSEMA		(B) DUE TO, OR AS A CONSEQUENCE OF: EMPHYSEMA		Many yrs	
(C) _____					
MEDICAL CERTIFICATION 3-27-1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 2		19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (N) (this hospital) attended the deceased from 1-16-1968 to 1-30-1968 , that (N) (we) lost saw the deceased alive on 1-30-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (N) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rodelio M. Lim		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-30-68	
23C. PHYSICIAN'S NAME (Type) RODELIO M. LIM		23D. ADDRESS CHH			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Feb. 2. 1968		24C. NAME OF CEMETERY or CREMATORY Holy Cross Cemetery	
24D. LOCATION (City, town, or county) (State) Harrisburg, Penna.		25A. DATE REC'D BY HEALTH DEPT. FEB 2 1968 Robert E. Tarkenton		25B. NAME OF REGISTRAR HENRY SANDER & SONS, INC Baltimore Md.	

✱

234

49-38-66 LB

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68-1318

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JULIA HOHMANN

2. DATE AND HOUR OF DEATH

1-31-68 5:15 PM 5.15 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)31 BALTO. CITY HOSPITALS
4940 EASTERN AVE.
BALTO., MD. 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

2217 WINTER LING ST. #21202

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED

NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

6-21-98

9. AGE (In years
last birthday)

69

10. Under 1 Yr. If Under 24 Hrs.

Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

? CZYZEWSKI

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

-

-

16. SOCIAL
SECURITY NO.

216-05-4832D

17. INFORMANT

RECORDS: BALTIMORE CITY HOSPITALS

ADDRESS

4940 EASTERN AVENUE BALTO., MD. #21224

18.

250.0 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

Ketoacidosis

(B) DUE TO, OR AS A CONSEQUENCE OF:

DIABETES

(C) ACID - SEVERE BRAIN INVOLVEMENT

4 YEARS

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

2 days.

7

MEDICAL CERTIFICATION

260X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

VTE - DEWATTI

19A. DATE OF OPERATION

O

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-31-1967 to 1-31-1968,
that (I) (we) last saw the deceased alive on 1-31-1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

G. ALARCON MA
DR. GRACIELA S. ALARCON
GRACIELA S. ALARCONAttending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

1-31-68

23C. PHYSICIAN'S
NAME (Type)

23D. ADDRESS

4940 EASTERN AVE., BALTO., MD. 21224
BALTO. CITY HOSPITALS24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

2/3/68

24C. NAME OF CEMETERY or CREMATORY

St. Stanislaus

24D. LOCATION

Baltimore,

(City, State or County)

Maryland

25A. DATE REC'D BY HEALTH DEPT.

FEB 2 1968

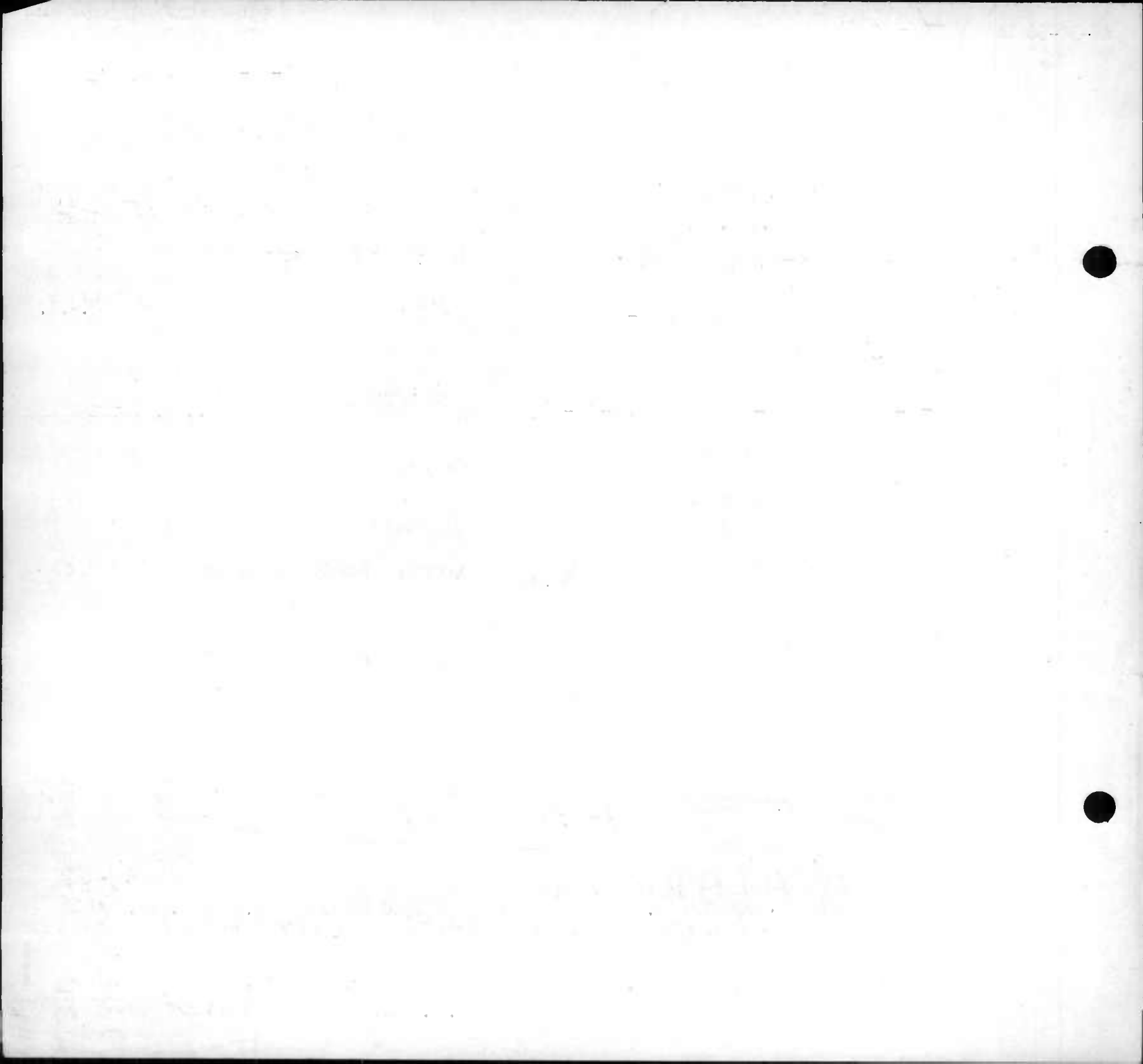
25B. NAME OF REGISTRAR

R. E. Farley MA

25C. FUNERAL DIRECTOR

M. F. SADOWSKI & SONS, 1808 EASTERN AVE

VS 150-REV. 1/1/68



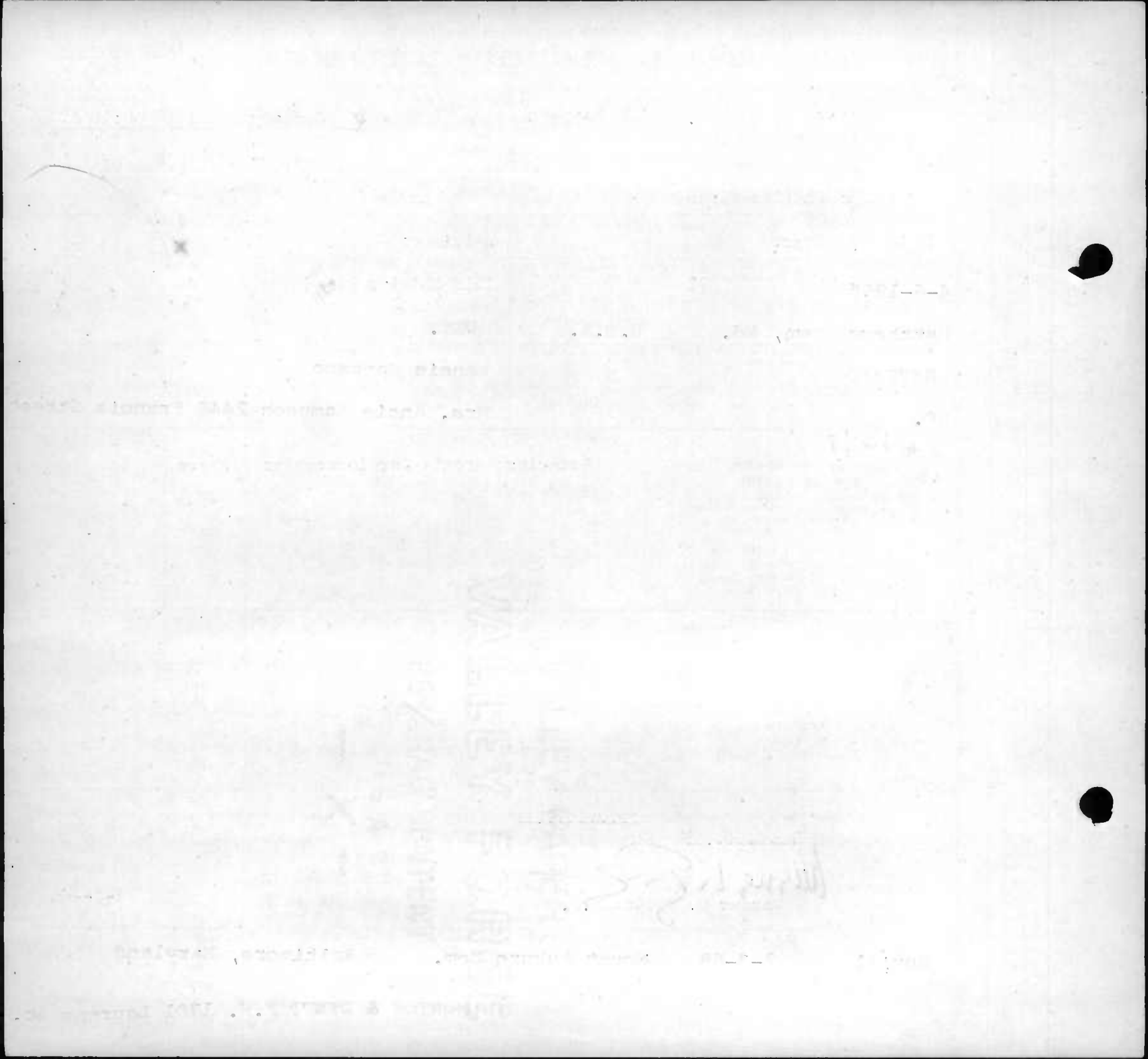
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 1319

REG. NO.

BIRTH NO.

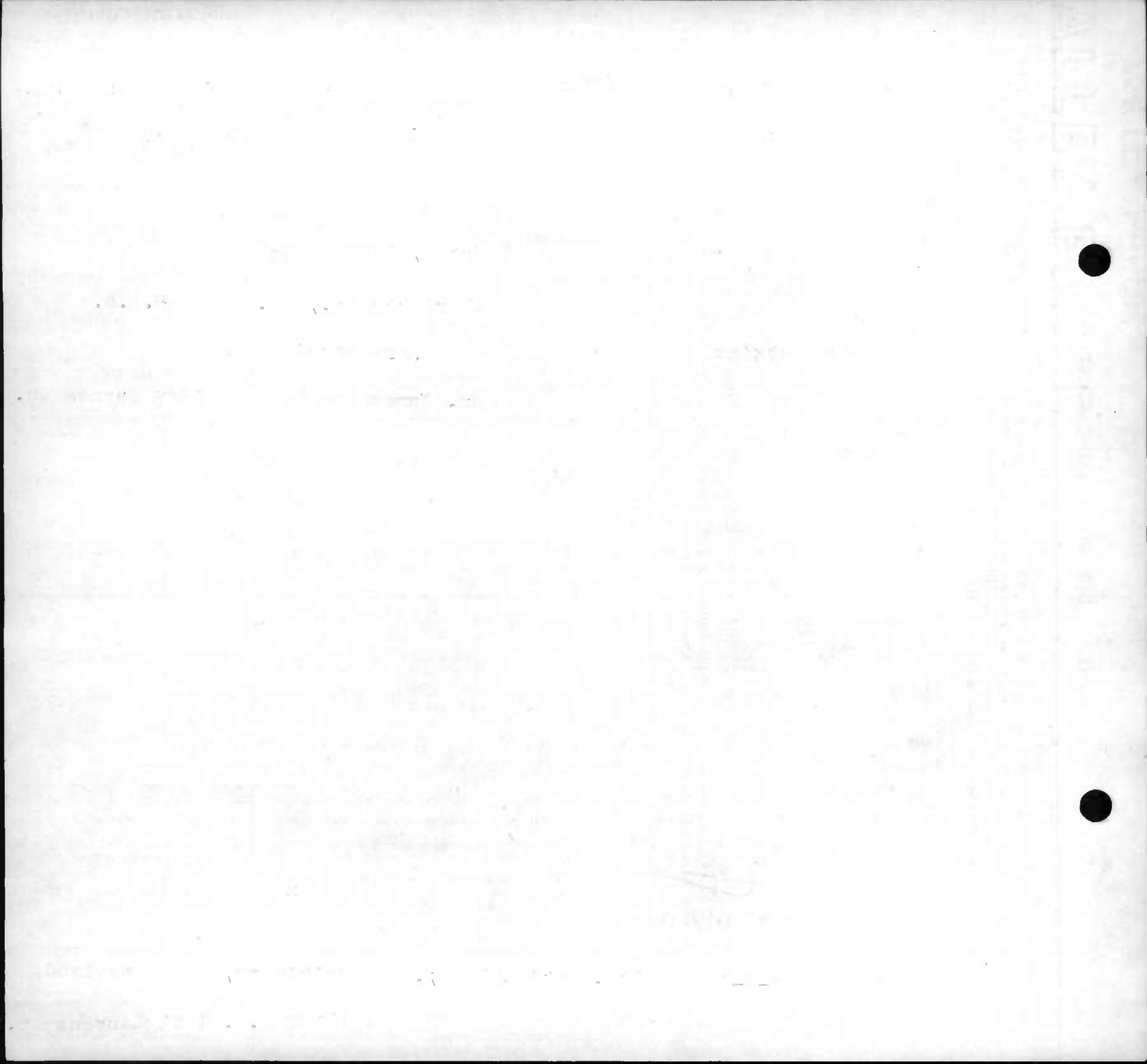
1. NAME OF DECEASED (Type or Print) JAMES H. SAMPSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> January 30, 1968 8:10 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1519 Shields Place		3. DATE PRONOUNCED DEAD Month Day Year Hour January 30, 1968 8:10 A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 14-02	
9. DATE OF BIRTH 4-6-1895		10. AGE (In years lost birthday) 72 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Matthews Town, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNK.		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED	
15. MOTHER'S MAIDEN NAME Annie Sampson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Mrs. Annie Sampson 2448 Francis Street	
19. 412.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 422.1 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-30-68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-3-68	
24C. NAME OF CEMETERY or CREMATORY Mount Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. FEB 2 1968		25B. NAME OF REGISTRAR Robert E. Spitz	
25C. FUNERAL DIRECTOR MORTON & DYETT F.H.		ADDRESS 1701 Laurens St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

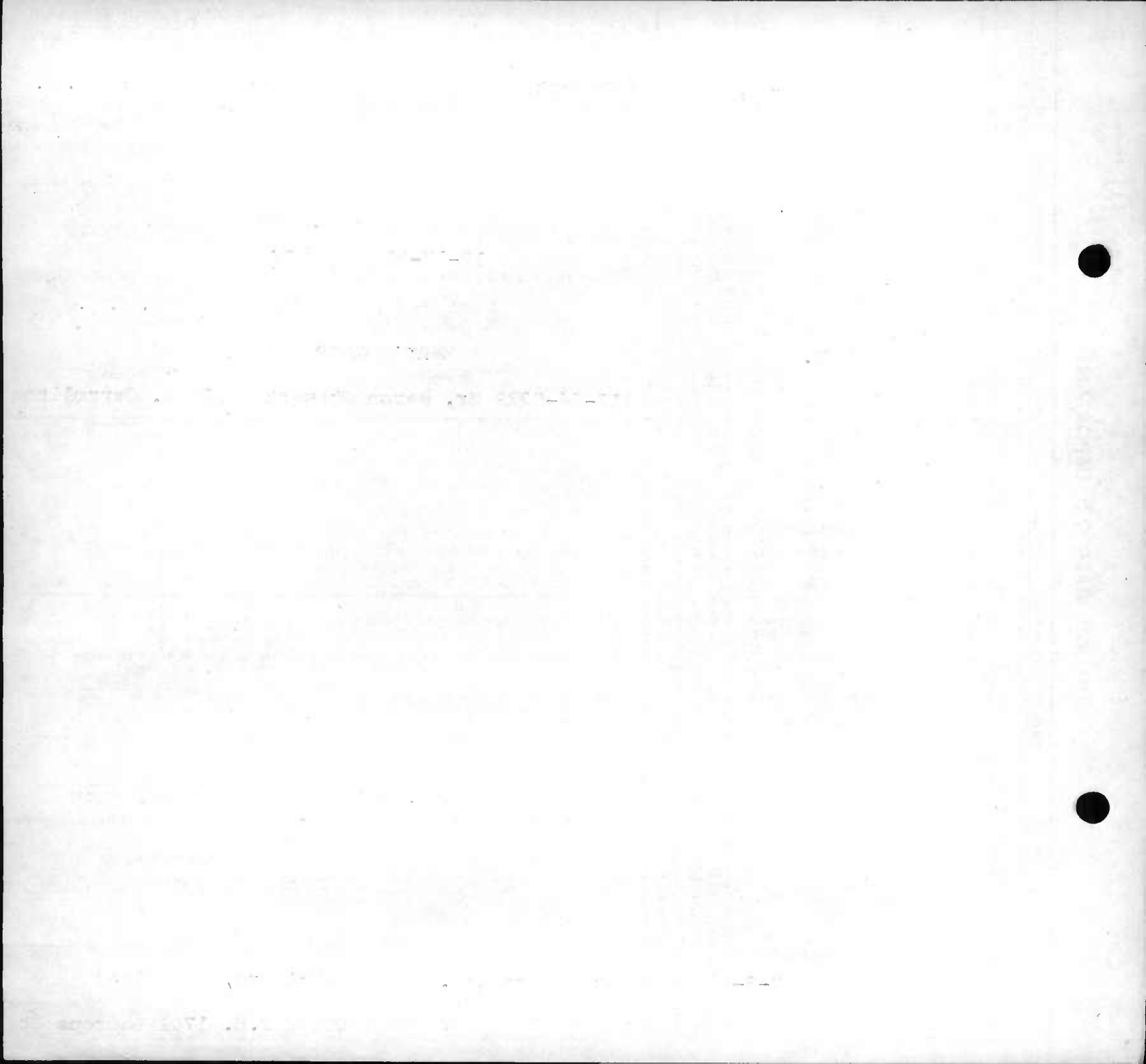
BALTIMORE CITY HEALTH DEPARTMENT										68-1320	
W-325 68-1320										REG. NO.	
1. NAME OF DECEASED (Type or Print) Watkins, Jacob (Jake)					2. DATE AND HOUR OF DEATH January 29, 1968 10:25 p. m.						
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital 1514 Division Street Baltimore, Maryland					4. USUAL RESIDENCE (Where deceased lived, if institution: residence, before admission) A. STATE Maryland B. COUNTY 15-01 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1824 Woodyear Street						
5. SEX Male		6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct , 1901 66		9. AGE (In years last birthday)		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed					10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Charlotte Co., Va.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jake Watkins					14. MOTHER'S MAIDEN NAME Mary Watkins						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT Mr. James Randle			ADDRESS 1649 Barnes St.	
18. 431.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) intra cerebral ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Haemorrhage secondary to senility										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION											
19A. DATE OF OPERATION 331X II											
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED											
20A. AUTOPSY? (Yes or No)											
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from January 27, 1968 19 to January 29, 1968 19, that (I) (we) last saw the deceased alive on January 29, 1968 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE RAJMANE								23B. DATE SIGNED January 30, 1968		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) RAJMANE								23D. ADDRESS 1514 Division Street Balti., Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 2-5-68		24C. NAME OF CEMETERY or CREMATORY Balto. National Cem.			24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. FEB 2 1968				25B. NAME OF REGISTRAR Robert E. Taylor				25C. FUNERAL DIRECTOR MORTON & DYETT F.H.			
								ADDRESS 1701 Laurens St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-1321</u>	
K-530 68-1321				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Kent, Leonia (Stewart)		January 30, 1968 12:30 p. m. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
39 Provident Hospital 1514 Division Street Baltimore, Maryland			Maryland		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			638 N. Carrollton Avenue		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
Female	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12-27-91	76	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Baltimore, Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
UNK.			MARTHA JANE PHILLIPS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		213-54-0329		Mr. Aaron Stewart 638 N. Carrollton	
18. <u>436.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CVA</u> (B) <u>Decubitus ulcer</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Senility</u> (C) _____		
19. DATE OF OPERATION			20A. AUTOPSY? (Yes or No)		
2			Yes		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED		
(APPROX.)			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>December 3, 1967</u> 19 to <u>January 30, 1968</u> 19, that (I) (we) last saw the deceased alive on <u>January 30, 1968</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>C. Laredo</u>				23B. DATE SIGNED January 30, 1968	
23C. PHYSICIAN'S NAME (Type) C. LAREDO				23D. ADDRESS 1514 Division Street	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		2-3-68		Mount Auburn Cem.	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR ADDRESS			
Baltimore, Maryland		MORTON & DYETT F.H. 1701 Laurens St			
25A. DATE REC'D BY HEALTH DEPT. FEB 2 1968		25B. NAME OF REGISTRAR E. Taylor		25C. FUNERAL DIRECTOR ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-460		68-1322		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1322	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) DOUGLAS TAYLOR			
2. DATE AND HOUR OF DEATH 1-26-68				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD UNIVERSITY HOSPITAL			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 28-02				5. SEX M 6. RACE Col			
C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
E. STREET AND NUMBER 4412 KATHLAND AVE				8. DATE OF BIRTH JAN 2-1888-50 9. AGE (In years birthd. m. d.) 79			
10A. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Retired				10B. KIND OF BUSINESS OR INDUSTRY Gen Contractor			
11. BIRTHPLACE (State or foreign country) Richmond VA				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Taylor				14. MOTHER'S MAIDEN NAME Lane Temple			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 219-01-1275A			
17. INFORMANT REBECCA Taylor				ADDRESS Richmond VA			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) MULTILOBAR PNEUMONIA				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. RESPIRATORY FAILURE				(B) DUE TO, OR AS A CONSEQUENCE OF: 2 days			
(C) _____							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ANEMIA							
19A. DATE OF OPERATION 490X		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED II		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1-23 19 68 to 1-26 19 68 , that (I) (we) lost saw the deceased alive on 1-26 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE B. A. Portway				23B. DATE SIGNED 1-26-68		23C. PHYSICIAN'S NAME (Type) _____	
24A. BURIAL CREMATION, REMOVAL (Specify) Burn				24B. DATE 2/1/68		24C. NAME OF CEMETERY OR CREMATORY mt Auburn	
24D. LOCATION (City, town, or county) (State) Baltimore				25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		25B. NAME OF REGISTRAR W. E. Taylor	
25C. FUNERAL DIRECTOR Marshall P. Hays				25D. ADDRESS 638 N. Guilmon St			

UNIVERSITY HOSPITAL
M. Col. 11
JAN 2-1980

Gen. Secretary, University of
Jamaica
Jamaica
21-01-1980
M. Col. 11

RESPIRATORY FAILURE

APR 1980

UNIVERSITY HOSPITAL
Jamaica
1-22-80
1-22-80
1-22-80

James M. M. M. M.
Jamaica
Jamaica
Jamaica

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
REG. NO. 68-1323

68-1323 CERTIFICATE OF DEATH

BIRTH NO. P-400

1. NAME OF DECEASED (Type or Print) JOHN A. POWELL-ALFRED POWELL DATE AND HOUR OF DEATH JAN. 31-1968 115 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 812 BROOKS LANE 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD B. COUNTY 13-01

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 812 BROOKS LANE C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES ☒ NO ☐

5. SEX M 6. RACE Colored 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH JULY 16-1896 9. AGE (In years last birthday) 71 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CATERER'S HELPER 10B. KIND OF BUSINESS OR INDUSTRY MD BALTO MD 11. BIRTHPLACE (State or foreign country) MD BALTO MD 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME CLARENCE H. POWELL 14. MOTHER'S MAIDEN NAME SUSIE FOREMAN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 16. SOCIAL SECURITY NO. 212-03-7339A 17. INFORMANT James Powell 1406 N. ... ADDRESS ...

18. 410.9 I CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CORONARY THROMBOSIS

ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A): #20.1 II

19A. DATE OF OPERATION 7/22/67 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED No 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7/22/67 19 to 1/20/68 19, that (I) (we) last saw the deceased alive on 1/20/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE [Signature] 23B. DATE SIGNED 2/1/68 Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23C. PHYSICIAN'S NAME (Type) HARRIS DENNARDINE 23D. ADDRESS 970 W. ...

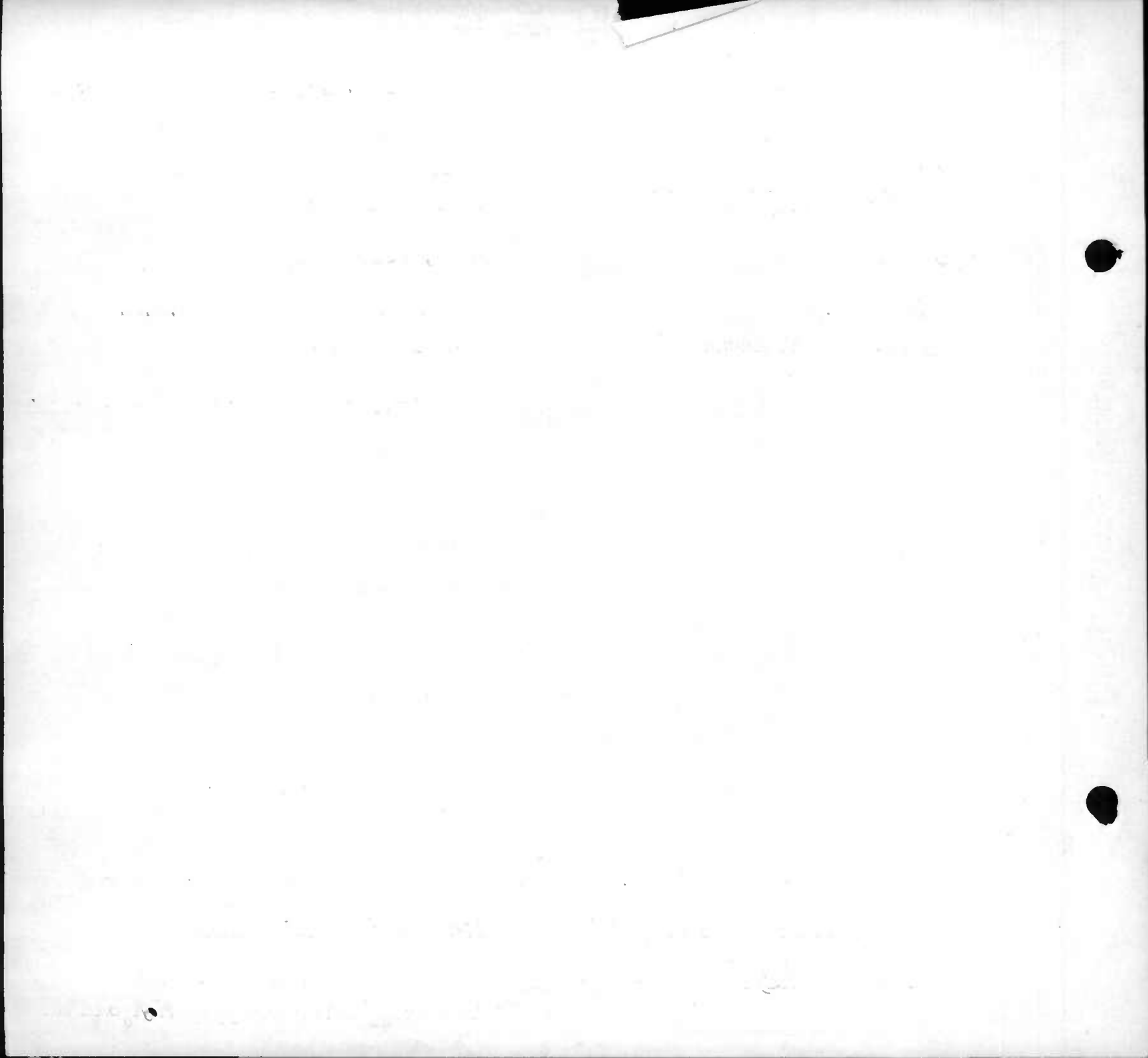
24A. BURIAL CREMATION, REMOVAL (Specify) Burned 24B. DATE 2/5/68 24C. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL BALTO MD 24D. LOCATION (City, town, or county) (State) BALTO MD

25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968 25B. NAME OF REGISTRAR Robert E. ... 25C. FUNERAL DIRECTOR James ... ADDRESS 638 N. ...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				7	
68- 1324				68- 1324	
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Anna Mary Schleupner</i>			2. DATE AND HOUR OF DEATH <i>Feb. 1, 1968</i> <i>6:30 P.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>10-01</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Little Sisters Of The Poor</i> <i>1200 Valley Street</i>			C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <i>1200 Valley St</i>					
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 3, 1880</i>	9. AGE (In years last birthday) <i>87</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home Maker</i>			11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>George J Schleupner</i>			14. MOTHER'S MAIDEN NAME <i>Mary Fleischmann</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO.		
17. INFORMANT <i>Miss Mary L Schleupner</i>			ADDRESS <i>1233 E Belv.</i>		
18. <i>481 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH <i>Pulmonary edema</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Rt. lower lobe pneumonia</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. DATE OF OPERATION <i>490 X II</i>			20A. AUTOPSY? (Yes or No)		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <i>1967</i> to <i>Feb 1</i> <i>1968</i> , that (I) (we) last saw the deceased alive on <i>Feb. 1</i> <i>1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Stanley Ankudas M D</i>			23B. DATE SIGNED <i>2-2-68</i>		
23C. PHYSICIAN'S NAME (Type) <i>Stanley Ankudas M D</i>			23D. ADDRESS <i>1101 Maiden Choice Lane</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>2/5/68</i>		
24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>FEB 2 1968</i>			25B. NAME OF REGISTRAR <i>Robert E. Fairbanks</i>		
25C. FUNERAL DIRECTOR <i>Leonard J Ruck Inc</i>			ADDRESS <i>5305 Harford Rd</i>		



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 1325

REG. NO.

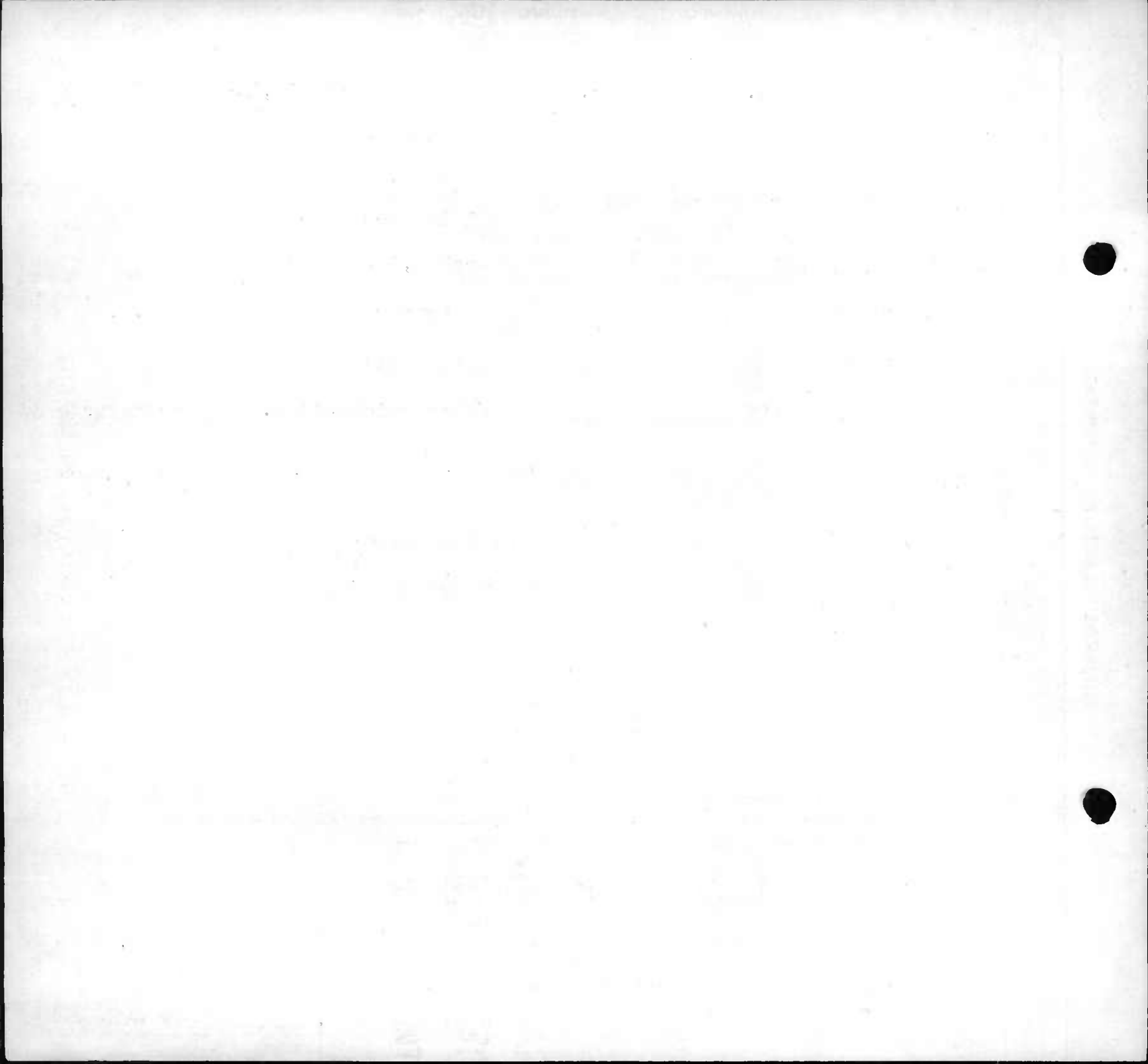
BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOSE ANTONIO IRIZARRY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 99 Church Home & Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour January 12, 1968 5:15 P.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
9. DATE OF BIRTH 1913		10. AGE (In years lost birthday) 54	
11. BIRTHPLACE (State or foreign country) Puerto Rico		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 702-03-2828	
18. INFORMANT Mrs Manuela Ortiz, 642 Vermont St., Brooklyn, New York		15. MOTHER'S MAIDEN NAME Emilia Suarez	
19. 3-7-81 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Bronchopneumonia due to Fatty metamorphosis of liver		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. AUTOPSY? (Yes or No) (Partial) Yes	
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-2-1968	
24C. NAME OF CEMETERY or CREMATORY Mt. Carmel		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. FEB 2 1968		25B. NAME OF REGISTRAR Robert E. Farkley	
25C. FUNERAL DIRECTOR Lilly & Zeiler Inc.		ADDRESS 1901 Eastern Ave.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-1326</u>
68-1326				CERTIFICATE OF DEATH
BIRTH NO.		2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print)		January 30, 1968 5:10 P. M.		
Lena R. Weichmuller.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE B. COUNTY		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Maryland		
08 1616 Northbourne Road		C. CITY OR TOWN D. INSIDE CITY LIMITS?		
		Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER		
		1616 Northbourne Road		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	March 8, 1889	78
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Housewife				Germany
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?
Unknown		? Roll		U.S.
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
no no		?		Helen Weichmuller. 1616 Northbourne Rd
18. 412.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Edema 5 minutes		
ANTECEDENT CAUSES		(B) Cardio-Vascular Hypertensive Disease 8 years		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Atherosclerosis 8 years		
443X II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (the hospital) attended the deceased from June 1967 to January 30, 1968, that (I) (we) last saw the deceased alive on January 29, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE		23B. DATE SIGNED		
Michael J. Dausch M.D.		2-1-68		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
Michael J. Dausch M.D.		4636 Belair Road - Balto. Md 21206		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)
Burial	2/3/68	Meadowridge Cemetery		Wash, Blvd Md
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS
FEB 2 1968		Robert E. Tasky		Austin E. Donovan, 3818 Roland Ave



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1327

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-1327

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Harry J. Bystry		2. DATE AND HOUR OF DEATH 1/31/68 4:20 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD SOUTH BALTIMORE GENERAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Anne Arundel		5. AGE (In years last birthday) 48 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
FULL NAME OF HOSPITAL OR INSTITUTION 43 SOUTH BALTIMORE GENERAL HOSPITAL		C. CITY OR TOWN Basadena		D. INSIDE CITY LIMITS? = YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 211th Street		F. GREEN HAVEN Green Haven			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/23/19	9. AGE (In years last birthday) 48	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rigger		10B. KIND OF BUSINESS OR INDUSTRY Md. Dry Dock		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME William Bystry		14. MOTHER'S MAIDEN NAME Lottie Odahosha		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) WW 11 Army		16. SOCIAL SECURITY NO. 215-05-9442		17. INFORMANT Mary Catherine Bystry-Same as # 4	
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Massive blood loss		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Massive blood loss		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ~ 1 hour	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 163X II		(B) DUE TO, OR AS A CONSEQUENCE OF: Erosion of vascular bundle to left lung		~ 1 hour	
(C) Carcinoma of left lung				1 year	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 163X		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 1/29/68 19 to 1/31/68 19, that (X) (we) last saw the deceased alive on 1/31/68 19 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John Albert Bigbee, M.D.				23B. DATE SIGNED 1/31/68	
23C. PHYSICIAN'S NAME (Type) John Albert Bigbee, M.D.				23D. ADDRESS S.B.G.H. - 1213 Light Street	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/3/1968		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
24D. LOCATION (City, town, or county) (State) Brooklyn, Maryland					
25A. DATE REC'D BY HEALTH DEPT. FEB 2 1968		25B. NAME OF REGISTRAR R. D. & E. J. J. J.		25C. FUNERAL DIRECTOR Singleton Funeral Home/Glen Burnie, Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-1328 CERTIFICATE OF DEATH

REG. NO.

68-1328

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

INGRAM HENRY W

2. DATE AND HOUR OF DEATH

1/31/68

6:45AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

LUTHERAN HOSPITAL OF MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE MARYLAND B. COUNTY Baltimore

C. CITY OR TOWN BALTIMORE 21229 D. INSIDE CITY LIMITS? YES ☒ NO ☐

E. STREET AND NUMBER 4425 ALAN DR

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

8-18-13

9. AGE (In years last birthday)

54 YRS.

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

Dry Wall Installer

11. BIRTHPLACE (State or foreign country)

FRANKLIN Co., Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

CHARLIE INGRAM

14. MOTHER'S MAIDEN NAME

VIVIAN P. CANNADAY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL SECURITY NO.

579-12-0821

17. INFORMANT

MRS LOTTIE B. INGRAM (Wife)

ADDRESS

Same as #2

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

Respiratory failure due to chronic obstructive

BRONCHOPULMONARY disease

Emphysema

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

1/29/68

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

TRACHEOSTOMY

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)

(APPROX.)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from 1-20-68 19 to 1-31-68 19 that (we) last saw the deceased alive on 1-30-68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

P. P. Joshi

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1-31-68

23C. PHYSICIAN'S NAME (Type)

P. P. JOSHI M.D.

23D. ADDRESS

730 ASHBURTON ST, BALTIMORE

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

2-3-68

24C. NAME OF CEMETERY OR CREMATORY

Old Liberty Cemetery

24D. LOCATION

FRANKLIN Co., VA.

25A. DATE REC'D BY HEALTH DEPT.

FEB 2 1968

25B. NAME OF REGISTRAR

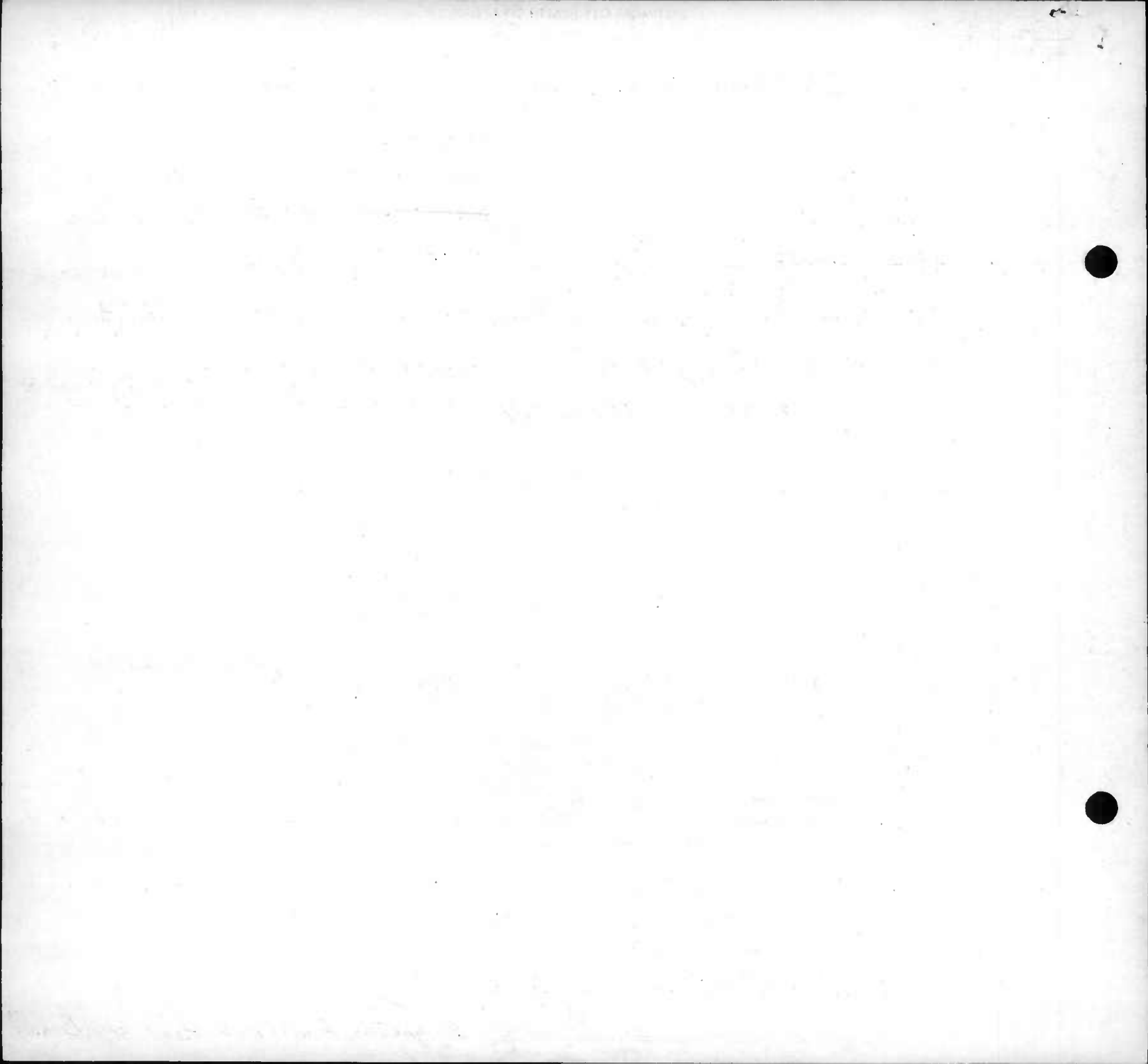
Robert E. Fabela

25C. FUNERAL DIRECTOR

Singleton Funeral Home

25D. ADDRESS

Chesapeake



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1329

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

REG. NO. 68-1329

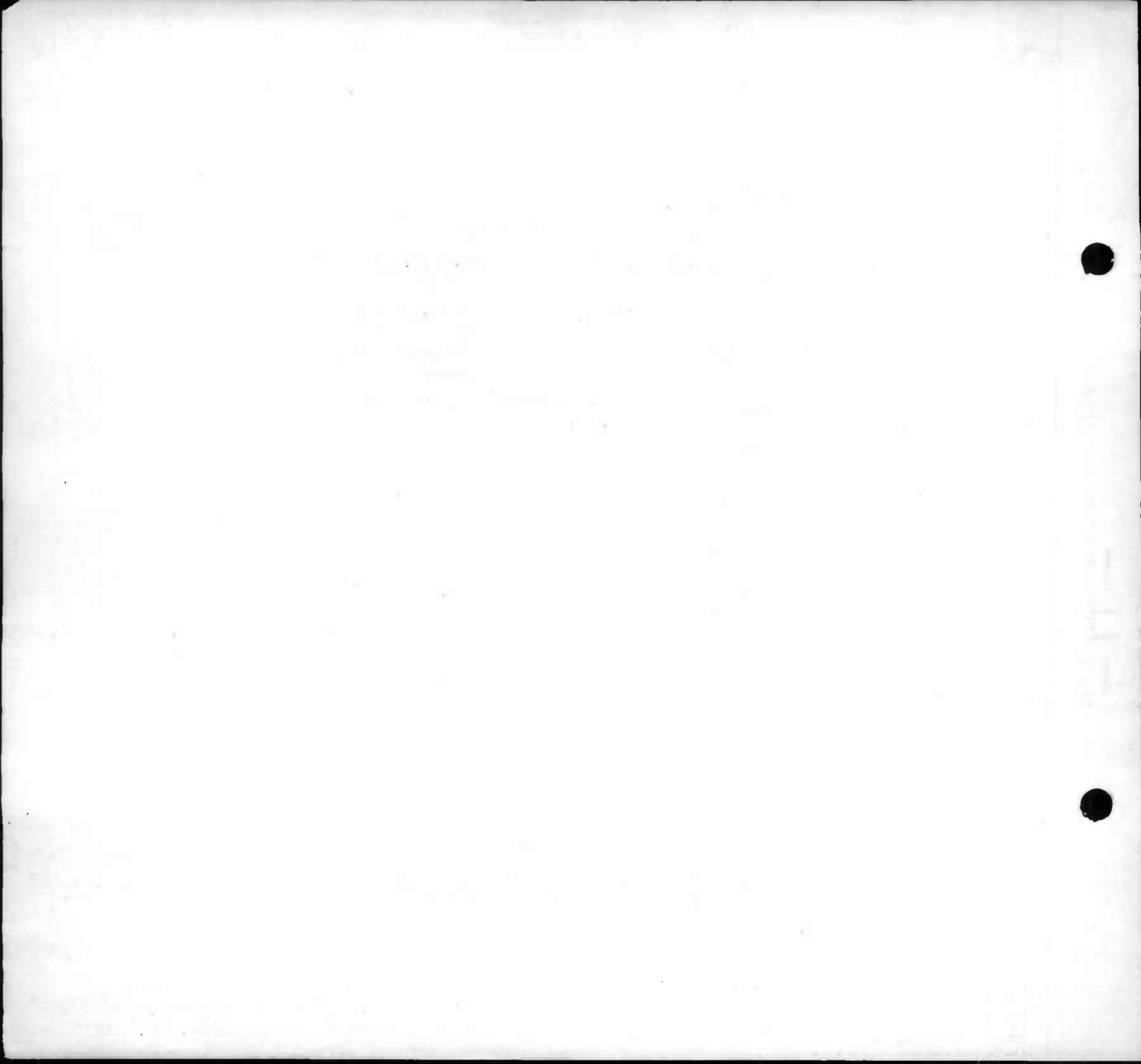
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Marie NMN Michel</i>		2. DATE AND HOUR OF DEATH <i>Jan 29 1968 2:50 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>53-00</i>		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i> <i>44</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>6711 Linden Ave.</i>		5. SEX <i>Female</i>		6. RACE <i>White</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10-18-97</i>		9. AGE (In years last birthday) <i>70</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HS WF.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland Baltimore</i>	
12. CITIZEN OF WHAT COUNTRY? <i>American</i>		13. FATHER'S NAME <i>Jahn Foeller.</i>		14. MOTHER'S MAIDEN NAME <i>Louis Lehneis</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-34-5210</i>		17. INFORMANT <i>Mr Rieman W. Michel 6711 Linden 21206</i>	
18. <i>153.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>153.0 II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Paralytic ileus</i> (B) <i>Metastatic Cancer Colon</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>Jan 18 1968</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cancer Colon</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>Jan 13 1968</i> to <i>Jan 29 1968</i> , that (I) (we) lost saw the deceased alive on <i>Jan 29 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Nabil Ibrahim Fanous</i>		23B. DATE SIGNED <i>Jan 29 1968</i>		23C. PHYSICIAN'S NAME (Type) <i>NABIL IBRAHIM FANOUS MD.</i>	
23D. ADDRESS <i>THE UNION MEMORIAL HOSPITAL</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>2-1-1968</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Co. Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>FEB 2 1968</i>	
25B. NAME OF REGISTRAR <i>Robert E. Fairbank</i>		25C. FUNERAL DIRECTOR <i>L. J. J. Funeral Home 7401 Belair Road</i>		25D. ADDRESS <i>(36)</i>	

THE CITY OF NEW YORK

IN SENATE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
68-1330		68-1330		68-1330	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Alice J. Johnson			Jan. 31, 1968 11:50 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
5651 Govane Avenue Baltimore, Md. 21212			Maryland 21212		
C. CITY OR TOWN (If outside city limits, write RURAL and give township)			D. STREET ADDRESS (If rural, give location)		
Baltimore			5651 Govane Avenue		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
Female	White	Never Married	Mar. 22, 1894	73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Homemaker		---		Balto. Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Clarence Johnson			Woodfield, Josephine		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No ---		220-48-0662J1		Edna Johnson (Sister) Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
183.0 I			CARCINOMA OF OVARY		8 years
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO		
			(B) DUE TO		
			(C) DUE TO		
175.0 II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0 1960		CARCINOMA OF OVARY		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
NO		NONE			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from November 1967 to January 31, 1968, that (1) (we) last saw the deceased alive on January 31, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
A.S. Chalfant				Jan 31, 1968	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. A.S. CHALFANT		6210 YORK ROAD, Baltimore 12, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		Fe. 3, 1968		Prospect Hill Cemetery	
25A. DATE REC'D. BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
FEB 2 1968		Robert E. Seitz		Eugenia K. Seitz, 5209 York Rd. Balto. Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 68-1331		CERTIFICATE OF DEATH		68-1331	
M.E. CASE NO.			DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) KENNEDY, MICHAEL J.			JANUARY 28, 1968 19:00 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTIMORE, MD. 21229			A. STATE MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) CARROLL C. 56-00 D. STREET ADDRESS (If rural, give location) SYKESVILLE 21784 RT 3 BOX 236 MARTZ RD.		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 12-14-81	9. AGE (In years last birthday) 86	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FIREMAN		10B. KIND OF BUSINESS OR INDUSTRY BALTO. CITY	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME MICHAEL KENNEDY			14. MOTHER'S MAIDEN NAME MARY BROWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 213-10 0145		
17. INFORMANT BALTO., MD. 21229			ADDRESS ST. AGNES RECORDS - WILKENS & CATON AVES		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MASSIVE Pulmonary Edema 10 hrs			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO CONGESTIVE Heart Failure - 10+ years A SCVD 20+ yrs		
19A. DATE OF OPERATION 1/24/68			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fractured Femur		
20A. AUTOPSY? (Yes or No) NO			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) NURSING Home		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) RANDALLSTOWN 03-00			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) JAN. 17, 1968		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>			21F. HOW DID INJURY OCCUR? Pt. Fell		
22. I certify that (I) (this hospital) attended the deceased from JANUARY 17 19 68 to JANUARY 28 19 68 , that (I) (we) last saw the deceased alive on JANUARY 28 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Frank M. Detorie</i>			23B. DATE SIGNED 1-28-68		
23C. PHYSICIAN'S NAME (Type) FRANK M. DETORIE			23D. ADDRESS WILKENS & CATON AVES. BALTO. 21229		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 2-1-68		24C. NAME OF CEMETERY or CREMATORY New Cathedral	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. FEB 2 1968		25B. NAME OF REGISTRAR Robert E. Jackson	
25C. FUNERAL DIRECTOR Harry W. Haight		25D. ADDRESS Sykesville, Md.			

1. 10:00 AM, 10/10/50

10/10/50, 10:00 AM

2. 10:00 AM, 10/10/50
3. 10:00 AM, 10/10/50
4. 10:00 AM, 10/10/50

5. 10:00 AM, 10/10/50
6. 10:00 AM, 10/10/50
7. 10:00 AM, 10/10/50

8. 10:00 AM, 10/10/50

9. 10:00 AM, 10/10/50

10. 10:00 AM, 10/10/50

11. 10:00 AM, 10/10/50

12. 10:00 AM, 10/10/50

13. 10:00 AM, 10/10/50

14. 10:00 AM, 10/10/50

15. 10:00 AM, 10/10/50

16. 10:00 AM, 10/10/50

17. 10:00 AM, 10/10/50

18. 10:00 AM, 10/10/50

19. 10:00 AM, 10/10/50

20. 10:00 AM, 10/10/50

21. 10:00 AM, 10/10/50

22. 10:00 AM, 10/10/50

23. 10:00 AM, 10/10/50

24. 10:00 AM, 10/10/50

25. 10:00 AM, 10/10/50

26. 10:00 AM, 10/10/50

27. 10:00 AM, 10/10/50

28. 10:00 AM, 10/10/50

29. 10:00 AM, 10/10/50

30. 10:00 AM, 10/10/50

31. 10:00 AM, 10/10/50

32. 10:00 AM, 10/10/50

33. 10:00 AM, 10/10/50

34. 10:00 AM, 10/10/50

35. 10:00 AM, 10/10/50

36. 10:00 AM, 10/10/50

37. 10:00 AM, 10/10/50

38. 10:00 AM, 10/10/50

39. 10:00 AM, 10/10/50

40. 10:00 AM, 10/10/50

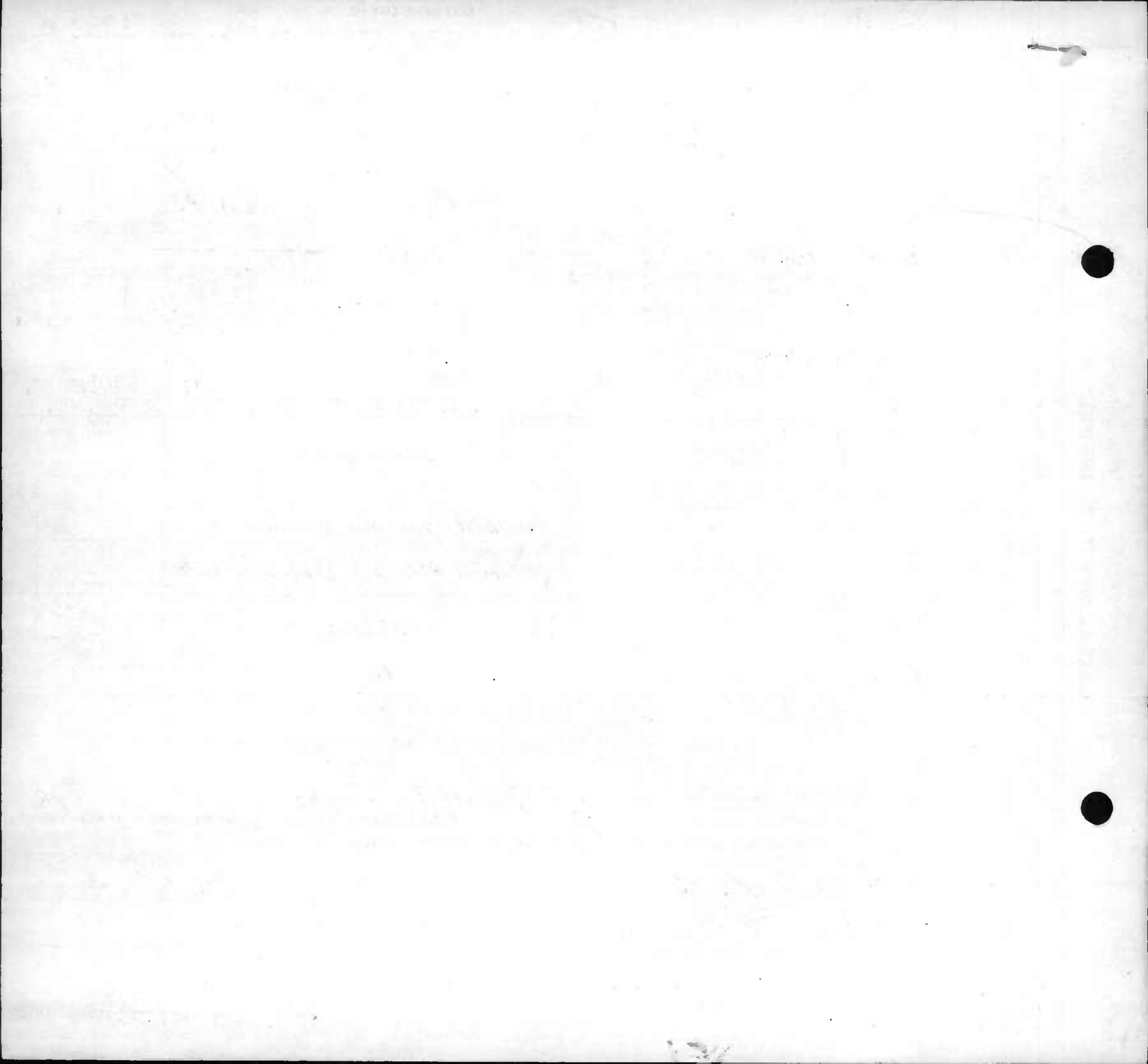
41. 10:00 AM, 10/10/50

42. 10:00 AM, 10/10/50

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

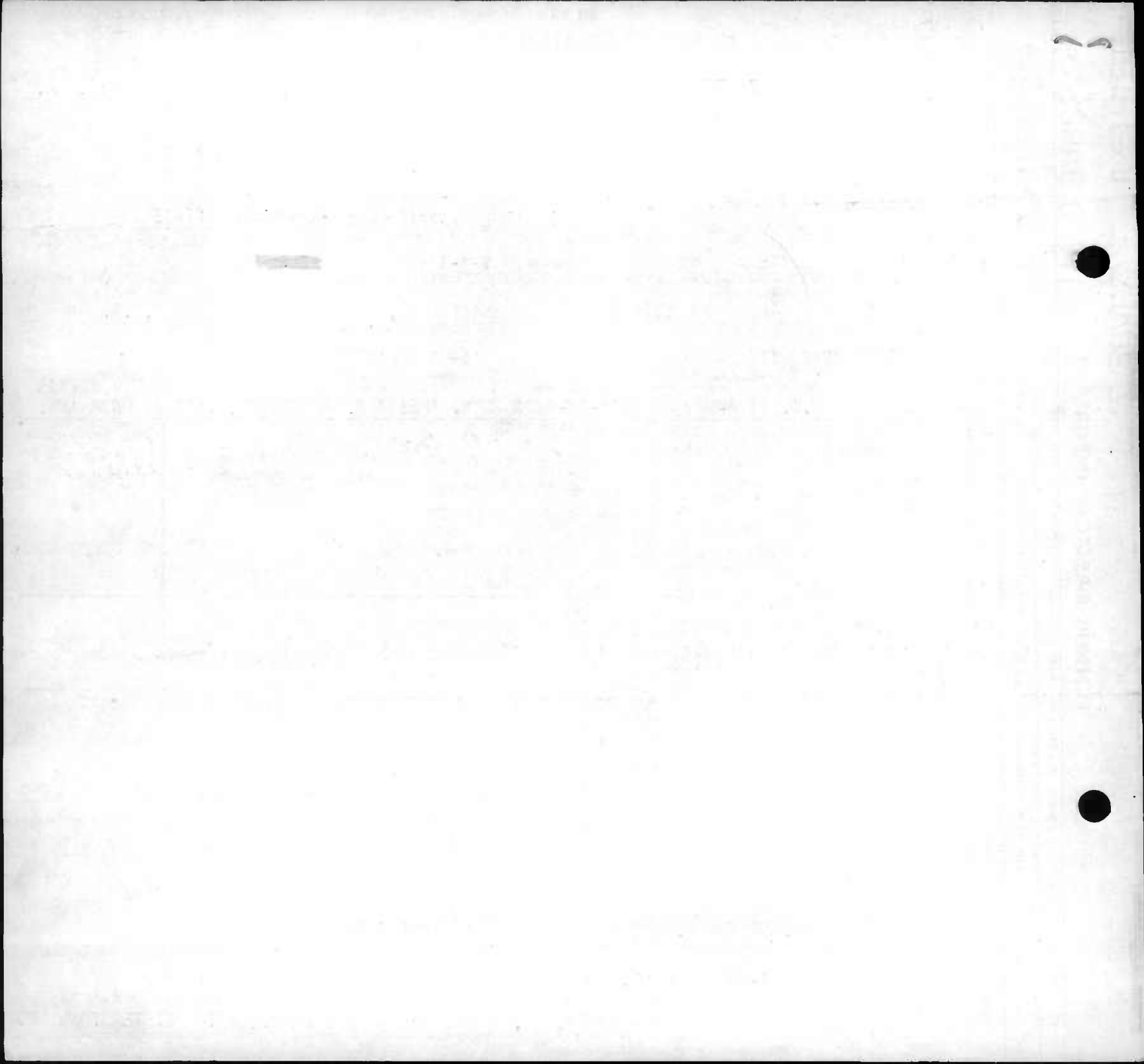
BALTIMORE CITY HEALTH DEPARTMENT										
REG. NO. 68-1332										
F-635-68-1332										
BIRTH NO.										
1. NAME OF DECEASED (Type or Print) <u>FRIEDMAN JEANETTE S.</u>					2. DATE AND HOUR OF DEATH <u>1-31-68</u> <u>9⁵⁶</u> <u>A</u> M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>15-13</u>					
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 SINAI HOSPITAL OF BALTO., INC.</u>					C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					E. STREET AND NUMBER <u>4502 REISTERSTOWN RD.</u>					
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/1/95</u>	9. AGE (In years lost birthday) <u>73</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>LEOPOLD SCHOCHET</u>					14. MOTHER'S MAIDEN NAME <u>ANNA JAFFE</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>MR. L. STANLEY FRIEDMAN</u>			ADDRESS <u>10411 GLEN HAVEN DR. SILVER SPRING, MD.</u>		
18. <u>412.01-1250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <u>Cardiorespiratory arrest</u>					CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral - vascular accident</u>					
					(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Hypertensive ASCVD / Diabetes Mellitus</u>					
					(C) <u>Infarction of small bowel -</u>					
19A. DATE OF OPERATION <u>1-18-68</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>ACUTE ABDOMEN - OBSTRUCTION</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (A PROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>1/18</u> <u>1968</u> to <u>1/31</u> <u>1968</u> , that (I) (we) last saw the deceased alive on <u>1/31</u> <u>1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <u>Thomas P. Smith</u>					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>1/31/68</u>		
23C. PHYSICIAN'S NAME (Type) <u>Thomas P. Smith</u>					23D. ADDRESS <u>SINAI HOSPITAL</u>					
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			24B. DATE <u>2-1-68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MIKRO KODESH BETH ISRAEL</u>			24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 2 1968</u>			25B. NAME OF REGISTRAR <u>Robert E. Finkbeiner</u>			25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 1333
B-623 68- 1333		CERTIFICATE OF DEATH		
BIRTH NO. 1. NAME OF DECEASED (Type or Print) MORRIS BERCOWITZ		2. DATE AND HOUR OF DEATH JANUARY 31, 1968 4:25 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3812 SEQUOIA AVENUE		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 15-10 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3812 SEQUOIA AVENUE #21215		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-4-1897	9. AGE (In years last birthday) 70 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME SIMON BERCOWITZ		
14. MOTHER'S MAIDEN NAME ANNA EDELBERG		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. II ARMY		
16. SOCIAL SECURITY NO. 112-10-0608		17. INFORMANT ADDRESS #21215 MRS. AMELIA D. BERCOWITZ, 3812 SEQUOIA AVE.		
18. CAUSE OF DEATH 412.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH aortic insufficiency cardiac failure arteriosclerosis cardiomyopathy (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 1954-13 years (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). #22.1 II none				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 210		20A. AUTOPSY? (Yes or No) no
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from Dec 19 48 to Jan 31 19 68 , that (I) (we) last saw the deceased alive on Jan 30 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Milton B. Kress				23B. DATE SIGNED 1/31/68
23C. PHYSICIAN'S NAME (Type) DR. MILTON B. KRESS		23D. ADDRESS MEDICAL ARTS BUILDING		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 2-1-68	24C. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW	24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE RECD BY HEALTH DEPT. FEB 2 1968		25B. NAME OF REGISTRAR Robert E. Taylor, MD		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN RD.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1334

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68- 1334

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GRUPP Mrs. CARRIE MAY

2. DATE AND HOUR OF DEATH

1-27-1968 10⁴⁵ P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

MONTEBELLO STATE HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

MARYLAND

BALTIMORE CO.

C. CITY OR TOWN

WHITEMARSH

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

BOX 486 PHILA ROAD 53-00

5. SEX

F

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

10-9-1901

9. AGE (In years last birthday)

66

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

PENNA

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

WILLIAM (GRUPP?)

14. MOTHER'S MAIDEN NAME

MARY E. (GRUPP?) DEARING

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

213-20-3880

17. INFORMANT

101 HAMPSHIRE RD. BALTO. MR. JOSEPH GRUPP (SON)

18. 412.01+250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute pulmonary embolism

(B) DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarction

(C) A.S.C.V.D. H.C.V.D. Diabetes mellitus 6 yrs

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Sudden (E30 min)

443X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

Diabetes mellitus & obesity yrs

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10-10-1967 to 1-27-1968. that (I) (we) last saw the deceased alive on 1-27-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.

23A. SIGNATURE

Zin U. Park M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1-27-68

23C. PHYSICIAN'S NAME (Type)

ZIN U. PARK M.D.

23D. ADDRESS

MONTEBELLO STATE HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

BURIAL

24C. NAME OF CEMETERY OR CREMATORY

BALTO. NATL

24D. LOCATION

(City, town, or county)

(State)

BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

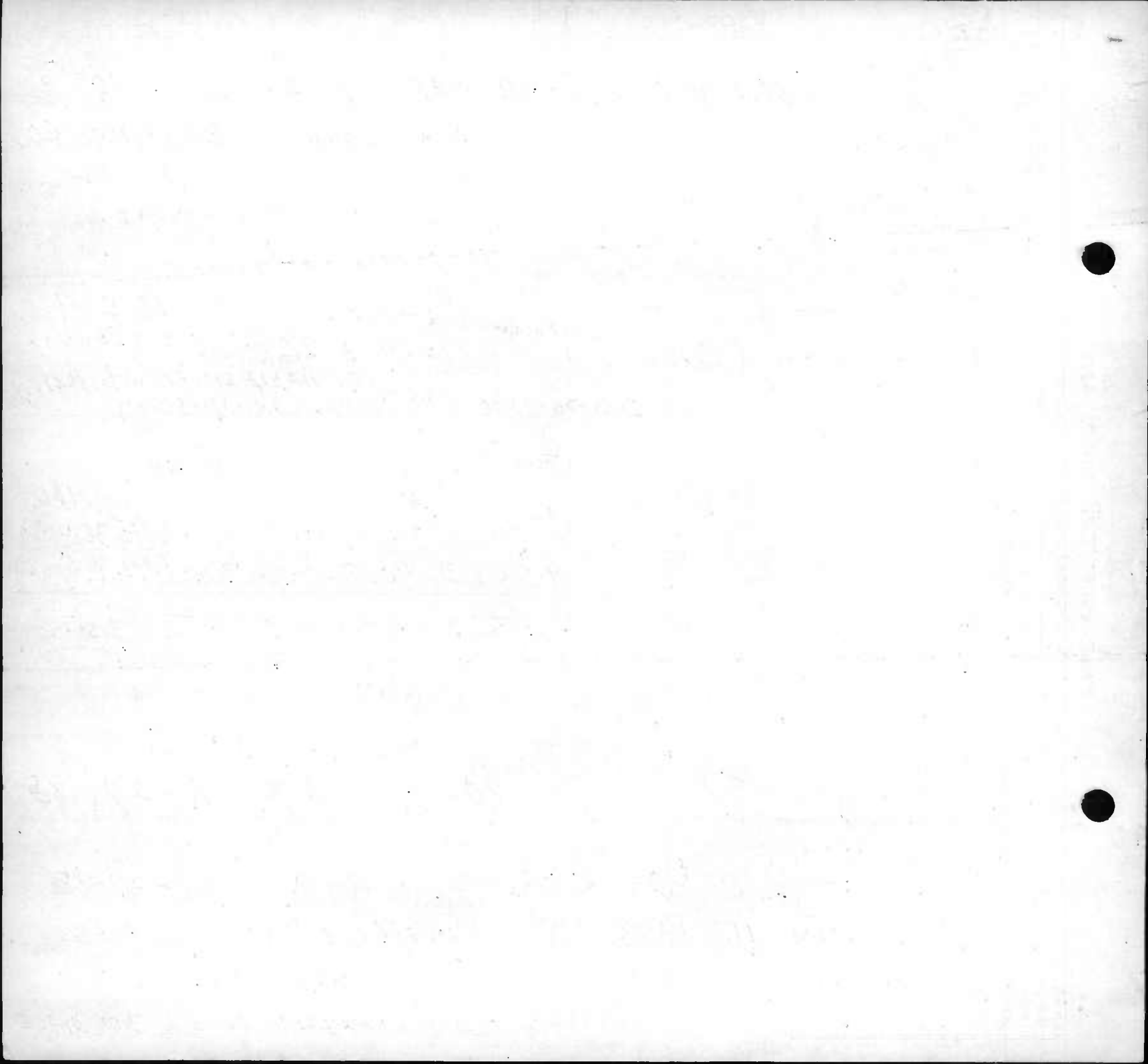
25C. FUNERAL DIRECTOR

ADDRESS

Robert E. J...

J.G. CANNELLY SONS

300 MACE



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1335

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-1335

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		John A. Greep		1-30-68 11:23 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore GENERAL Hosp.				A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX M.		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 2-6-87 80	
		Retired		11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Greep				14. MOTHER'S MAIDEN NAME ANN Kelly	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
UNK		213-07-9439		ANN JOHNSON ABOVE	
18. 412.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenic, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH Cerebrovascular accident (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) ASCVD (C) Bronchopneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days years 2 days	
422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Chronic obstruction pulmonary disease years			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No.	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 1/22 1968 to 1/30 1968, that (we) last saw the deceased alive on 1/30 1968 and that in () (aur) opinion death occurred on the date and hour and from the causes stated above. (We) (did) () view the body after death.					
23A. SIGNATURE Gerard D. Dobrzycki, Sr.				23B. DATE SIGNED 1/30/68	
23C. PHYSICIAN'S NAME (Type) Gerard D. Dobrzycki, Sr.				23D. ADDRESS 1213 Light Street.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 2/2/68		24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL	
24D. LOCATION BALTO. MD.		24E. NAME OF REGISTRAR Robert E. Fairbanks		24F. FUNERAL DIRECTOR J.G. CONNELLY SONS	
25A. DATE REC'D BY HEALTH DEPT. FEB 2 1968		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR 300 MACE	

[Faint, illegible text, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1336

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 1336

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Ernest Stone SR.

2. DATE AND HOUR OF DEATH

1-30-68 7¹⁰ A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

*North Charles Gen. Hosp.
2724 No. Charles St.*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland BALTOG 53-00

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐ NO ☒

E. STREET AND NUMBER

605 Maryland Ave

5. SEX

M

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

9-9-99

9. AGE (In years last birthday)

68

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Penn.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

David Stone

14. MOTHER'S MAIDEN NAME

Emma Lamborn

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

UNIK

16. SOCIAL SECURITY NO.

214-18-5512

17. INFORMANT

Hosp. chart

ADDRESS

18.

410.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

Chr. renal failure

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

& acute myocardial infarction

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Nephrosclerosis & atherosclerosis

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from *1-22-1968* to *1-30-1968*, that (I) (we) last saw the deceased alive on *1-30-1968* and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

German de la Torre

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1-30-68

23C. PHYSICIAN'S NAME (Type)

GERMAN DE LA TORRE

DEGREE

23D. ADDRESS

North Charles General Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

1/3/68

24C. NAME OF CEMETERY or CREMATORY

BELAIR MEM. GARDELS

24D. LOCATION

HARFORD

(City, town, or county)

(State)

MD.

25A. DATE REC'D BY HEALTH DEPT.

FEB 2 1968

25B. NAME OF REGISTRAR

Robert E. Fairbank

25C. FUNERAL DIRECTOR

J.E. CONNELLY SONS

ADDRESS

300 MAce

214-18-2000 Hoop Creek

7-4-02 63

Penon

Common Grounds

Mr. White

Letter

Handwritten

1-50- 26

1-30- 68

1
H-650

68-1337

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-1337

BIRTH NO.

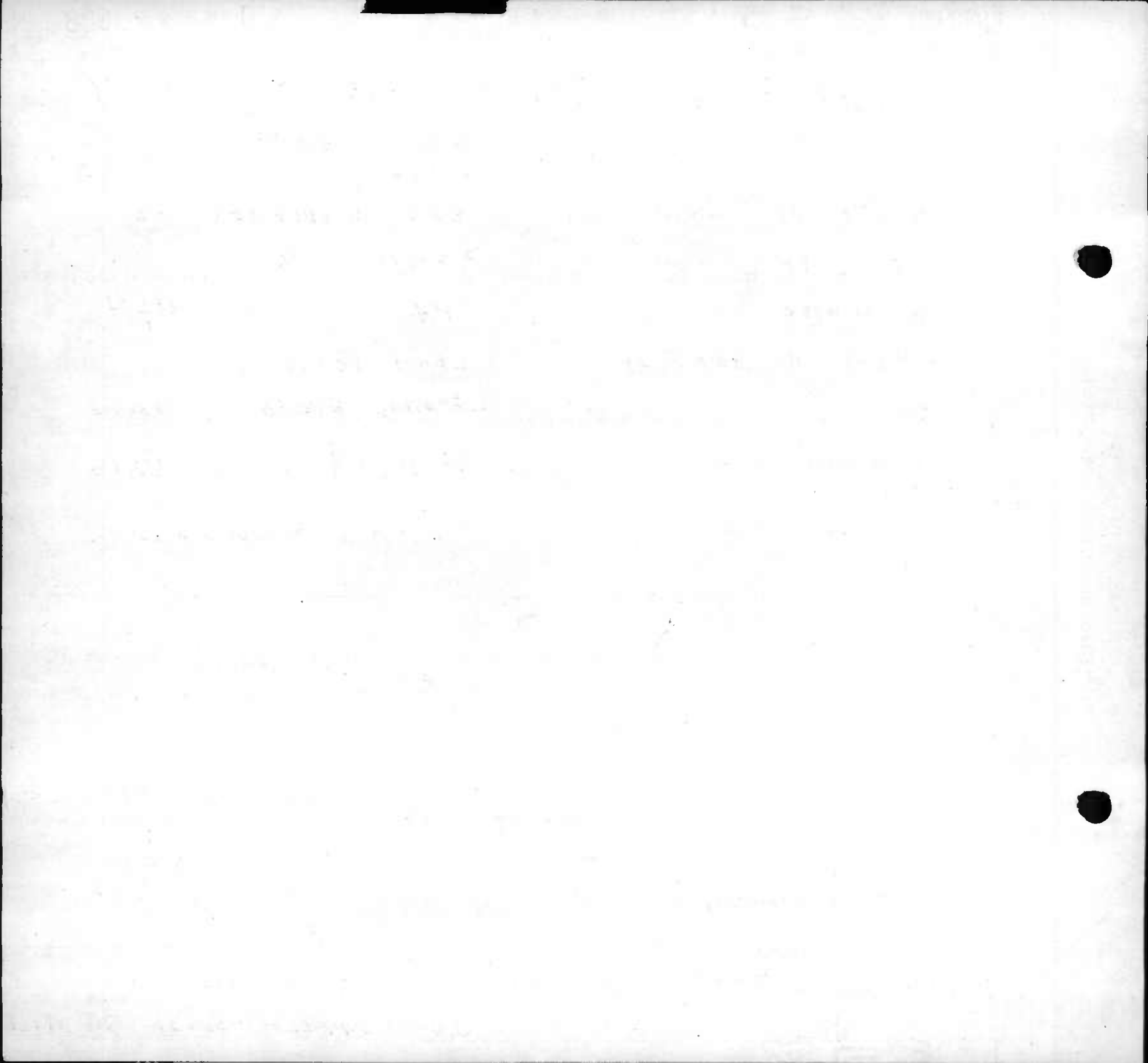
REG. NO.

1. NAME OF DECEASED (Type or Print) ISHMAEL HORNE JR.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> January 29, 1968 3:00 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour January 29, 1968 3:00 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTO. Co	
9. DATE OF BIRTH 12/25/43		10. AGE (In years last birthday) 24	
11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ISHMAEL HORNE SR.		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COUNTY	
15. MOTHER'S MAIDEN NAME NINA LEWIS		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES	
17. SOCIAL SECURITY NO. 2 12-42-2296		18. INFORMANT SANDRA HORNE	
19. CAUSE OF DEATH E965X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. E981X OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 1-27-68		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED Head wound	
21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Tavern		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Herb's Bar - 2400 E. Fayette Street	
22D. TIME OF INJURY (APPROX.) 1-27-68 9:30 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Shot during altercation		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED January 29, 1968		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	
24B. DATE 2/1/68		24C. NAME OF CEMETERY or CREMATORY BALTO. NATL.	
24D. LOCATION (City, town, or county) (State) BALTO. MD		25A. DATE REC'D BY HEALTH DEPT. FEB 2 1968	
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR J. C. CONNELLY SONS	
ADDRESS 300 MA...			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

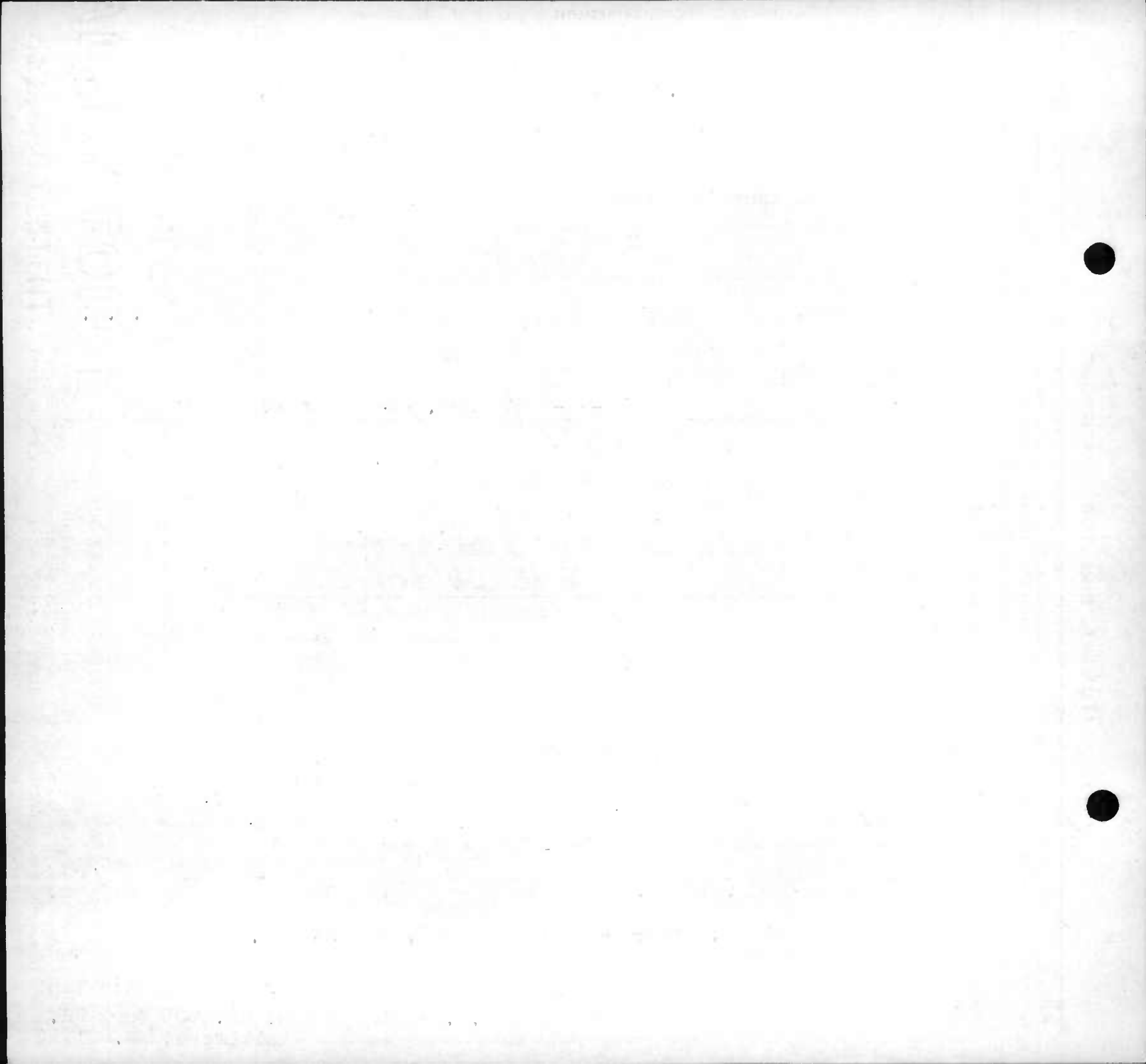
BALTIMORE CITY		REG. NO.	
68-1338		68-1338	
CERTIFICATE OF DEATH			
BIRTH NO. EVERD		REG. NO.	
1. NAME OF DECEASED (Type or Print) Head, Estelle Katherine		2. DATE AND HOUR OF DEATH 1/29/68 830 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTO	
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL.		C. CITY OR TOWN ESSEX D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX F 6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		8. DATE OF BIRTH 3/22/11 9. AGE (In years last birthday) 56	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PA.	
13. FATHER'S NAME CHRIST HOCKENFUSS		14. MOTHER'S MAIDEN NAME LENA DORR	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -	
17. INFORMANT LEONARD EVERD		ADDRESS ABOVE	
18. 750.91		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Rupture Aneurysm 12Hrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Subarachnoid Hemorrhage 24Hrs	
330X II		(C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 5	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 0		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 0	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 28 19 68 to Jan 29 19 68 , that (I) (we) last saw the deceased alive on Jan 29 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE F. J. Crossman, Jr MD		23B. DATE SIGNED 1/29/68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 2/2/68	
24C. NAME OF CEMETERY or CREMATORY LOU DON PARK		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. FEB 2 1968		25B. NAME OF REGISTRAR Robert E. Sullivan	
25C. FUNERAL DIRECTOR J.G. CONNELLY SONS		ADDRESS 300 MACE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

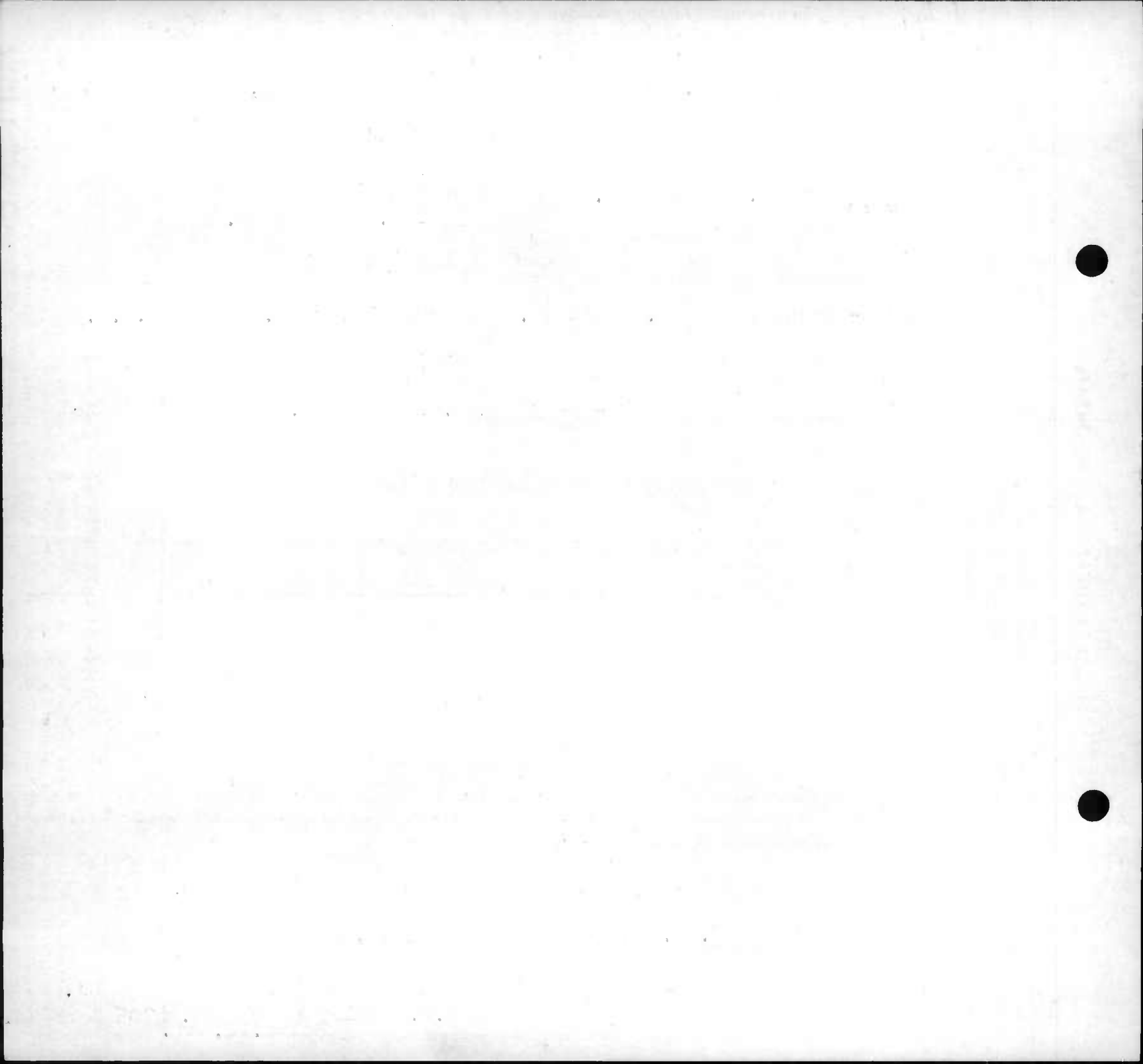
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-1339</u>
<p>BIRTH NO. <u>M-635</u></p> <p>1. NAME OF DECEASED (Type or Print) <u>George W. Martin</u></p>		<p>2. DATE AND HOUR OF DEATH <u>January 31, 1968</u> <u>7:00 P</u> M.</p>		
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>601 Tunbridge Road</u></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>601 Tunbridge Road</u></p>		
<p>5. SEX <u>M</u></p>	<p>6. RACE <u>W</u></p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>11/25/1882</u></p>	<p>9. AGE (In years last birthday) <u>85</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY <u>Dairy</u></p>		<p>11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u></p>
<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>		<p>13. FATHER'S NAME <u>Pat Martin</u></p>		
<p>14. MOTHER'S MAIDEN NAME <u>Hanna</u></p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWI</u></p>		
<p>16. SOCIAL SECURITY NO. <u>216-07-8527</u></p>		<p>17. INFORMANT <u>Mrs. Howard Isaacs</u> ADDRESS <u>(Same)</u></p>		
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>412.9 I</u></p>		<p>CAUSE OF DEATH <u>1. Arteriosclerotic Heart Disease - acute + chronic congestive failure</u> <u>2. occlusive arterial disease both lower extremities due to arteriosclerosis</u> <u>3. general arteriosclerosis</u></p>		
<p>19A. DATE OF OPERATION <u>4.0.0 II</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>both lower extremities due to arteriosclerosis</u></p>		
<p>20A. AUTOPSY? (Yes or No) <input type="checkbox"/></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/></p>		
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/></p>		
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input type="checkbox"/></p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <input type="checkbox"/></p>		
<p>21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR? <input type="checkbox"/></p>		
<p>22. I certify that (I) (this hospital) attended the deceased from <u>July 1960</u> to <u>Jan 31 1968</u>, that (I) <u>last</u> saw the deceased alive on <u>Jan 29 1968</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>				
<p>23A. SIGNATURE <u>Donald W. Mintzer</u></p>		<p>23B. DATE SIGNED <u>Feb 1968</u></p>		
<p>23C. PHYSICIAN'S NAME (Type) <u>Donald W. Mintzer</u></p>		<p>23D. ADDRESS <u>3009 Evergreen Ave.</u></p>		
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>24B. DATE <u>2/5/68</u></p>		
<p>24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National</u></p>		<p>24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u></p>		
<p>25A. DATE REC'D BY HEALTH DEPT. <u>FEB 2 1968</u></p>		<p>25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u></p>		
<p>25C. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u></p>		<p>ADDRESS <u>4905 York Rd. Baltimore, Md. 21212</u></p>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
M-320 68-- 1340					REG. NO. 68-- 1340						
BIRTH NO.					2. DATE AND HOUR OF DEATH						
1. NAME OF DECEASED (Type or Print) Henry B. Mathews					January 31, 1968 12 noon M.						
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)						
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3908 N. Charles St.					A. STATE Maryland						
					B. COUNTY						
C. CITY OR TOWN Baltimore					D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
					E. STREET AND NUMBER 3908 N. Charles St.						
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/11/1891	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Executive					10B. KIND OF BUSINESS OR INDUSTRY Comm. Credit Co.		11. BIRTHPLACE (State or foreign country) Rockville, Conn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Louis Pierre Mathews					14. MOTHER'S MAIDEN NAME Mary Burke						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI					16. SOCIAL SECURITY NO. 212-01-7388		17. INFORMANT Mrs. Katherine G. Mathews		ADDRESS (Same)		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 200.1 I LYMPHOSARCOMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 200.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Lymphosarcoma 2 yrs. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (1) (this hospital) attended the deceased from June 6 1958 to January 31 1968, that (1) (we) last saw the deceased alive on January 24 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Joseph D. B. King					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 2/1/68			
23C. PHYSICIAN'S NAME (Type) Joseph D. B. King					23D. ADDRESS Quadrangle, Village of Cross Keys						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 2/3/68		24C. NAME of CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Baltimore Md.				
25A. DATE REC'D BY HEALTH DEPT. FEB 2 1968			25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.			ADDRESS 4905 York Rd. Balto. 12, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-1341</u>	
BIRTH NO. <u>M-624</u>				68-1341 CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>MARZULLO, MARGIE Lee</u>			2. DATE AND HOUR OF DEATH <u>1-31-68</u> <u>9:00 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 UNION MEMORIAL HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Reisterstown</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>REISTER TOWN ROUTE #2 Box-190A</u>		
5. SEX <u>F</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-03-27</u>	9. AGE (In years lost birthday) <u>40</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Soc. Sec. Administration</u>		11. BIRTHPLACE (State or foreign country) <u>Winston-Salem, N. C.</u>	
13. FATHER'S NAME <u>ROBERT MERITT</u>			14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT ADDRESS <u>Hosp. Rec.</u>	
18. <u>431.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Intracerebral hemorrhage</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>331 X II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>W. K. W.</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1-31-68</u> 19 <u>68</u> to <u>1-31</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1-31</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Sam V. Desquizado</u>				23B. DATE SIGNED <u>1-31-68</u>	
23C. PHYSICIAN'S NAME (Type) <u>RAUL V. DESQUIZADO MD.</u>				23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>2/3/68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Wash. Blvd. Howard County Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>FEB 2 1968</u>			
25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>B. Vernon Johnson</u>			
25D. ADDRESS <u>4611 Park Heights Ave.</u>					

THE NEW YORK PUBLIC LIBRARY

ASTOR LENOX TILDEN FOUNDATION

P-3621

68-1342

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-1342

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Ruth E. Peters Sr.

2. DATE AND HOUR OF DEATH

2:30 PM 3 Feb. 1968-2:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

37 Mary Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland - BALTIMORE

C. CITY OR TOWN

E. STREET AND NUMBER

2430 ZION RD

D. INSIDE CITY LIMITS?

YES ☒NO ☐

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

20 Nov 1910

9. AGE (In years
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.

Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Dispatcher

10B. KIND OF BUSINESS OR INDUSTRY

Newspaper

11. BIRTHPLACE (State or foreign country)

Bal. Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Ernest M. Peters.

14. MOTHER'S MAIDEN NAME

Barbara Hoffman

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

NONE

16. SOCIAL
SECURITY NO.

215-09-9541

17. INFORMANT

Ruth Peters 2430 ZION RD.

ADDRESS

18. 4300 I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Subarachnoid hemorrhage

Plus

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Hypertension

? yes

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

White At
Work ☐Not White
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from 3 Feb. 1968 to 3 Feb. 1968
that (we) last saw the deceased alive on 3 Feb. 1968 and that (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (We) (did) (did not) view the body after death.

23A. SIGNATURE

Harris Feldman

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

3 Feb 1968

23C. PHYSICIAN'S
NAME (Type)

HARRIS FELDMAN

DEGREE

23D. ADDRESS

Mary Ave.

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

2-6-68

24C. NAME OF CEMETERY OR CREMATORY

LONDON PARK

24D. LOCATION

BALTIMORE, MD.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

FEB 5 1968

25B. NAME OF REGISTRAR

R. E. Feldman

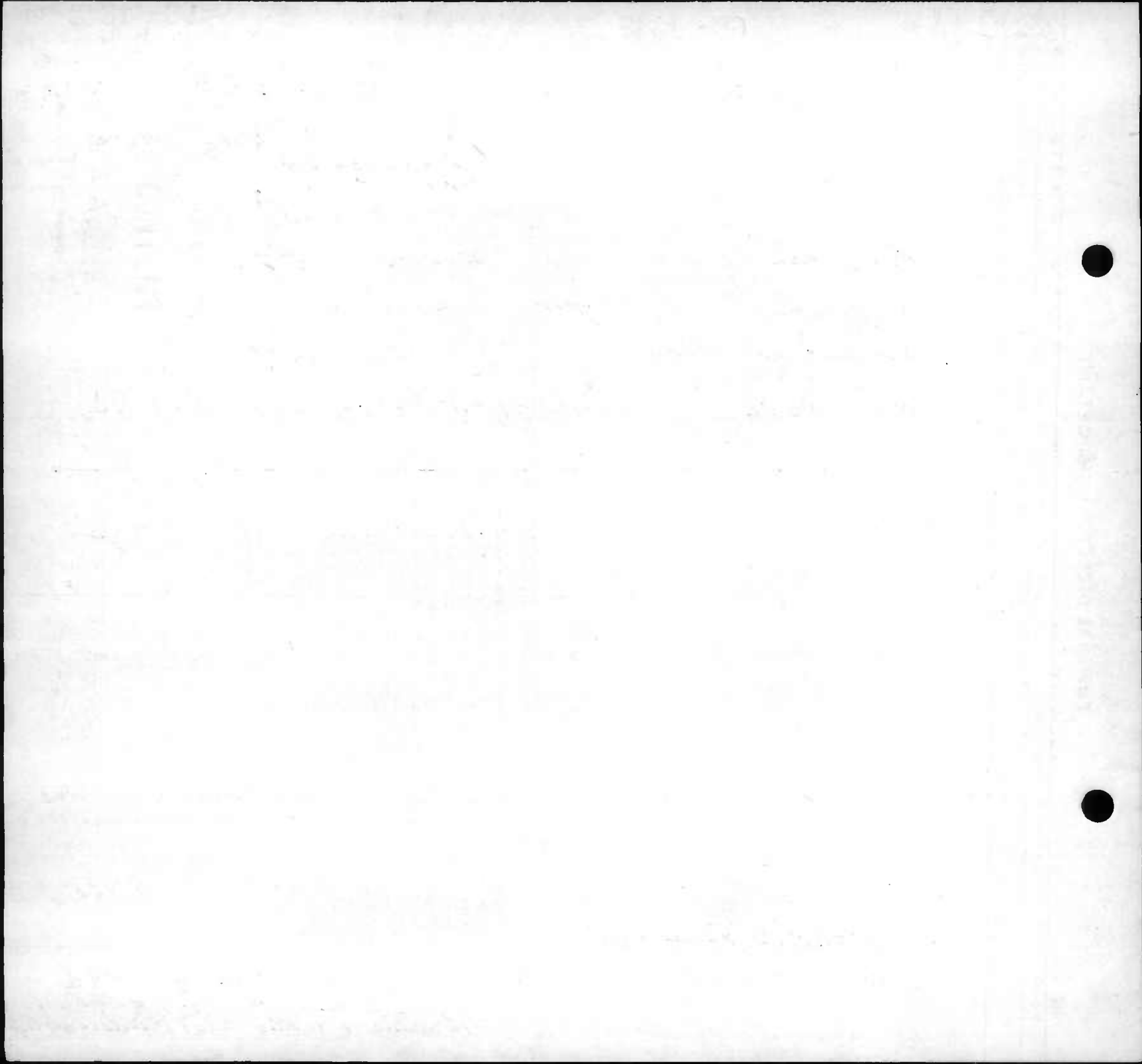
25C. FUNERAL DIRECTOR

Geo. L. Schwab Funeral Home
Armando W. Miller 2101 Frederick Ave.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



68-1343

BALTIMORE CITY HEALTH DEPARTMENT

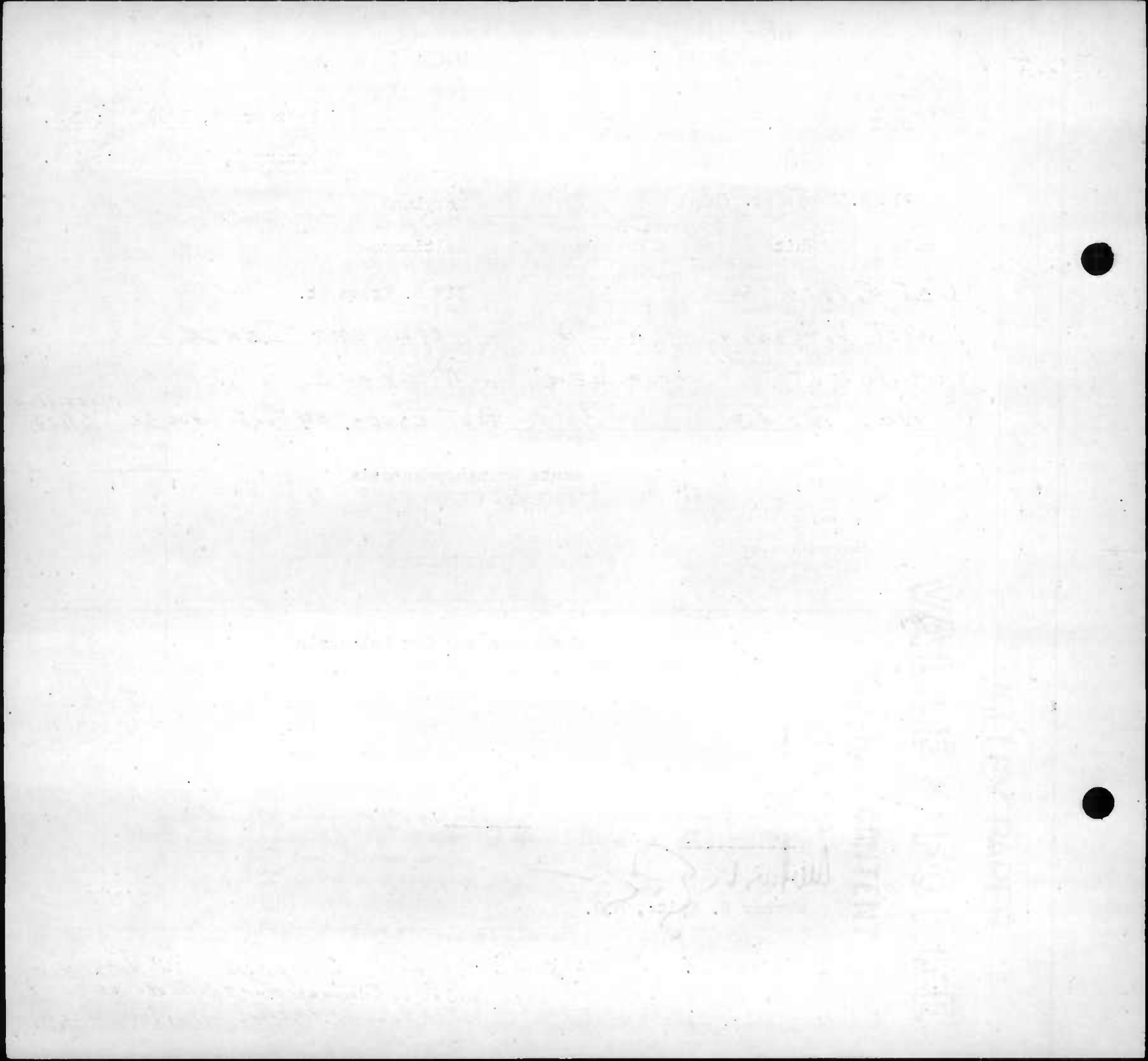
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-1343

REG. NO.

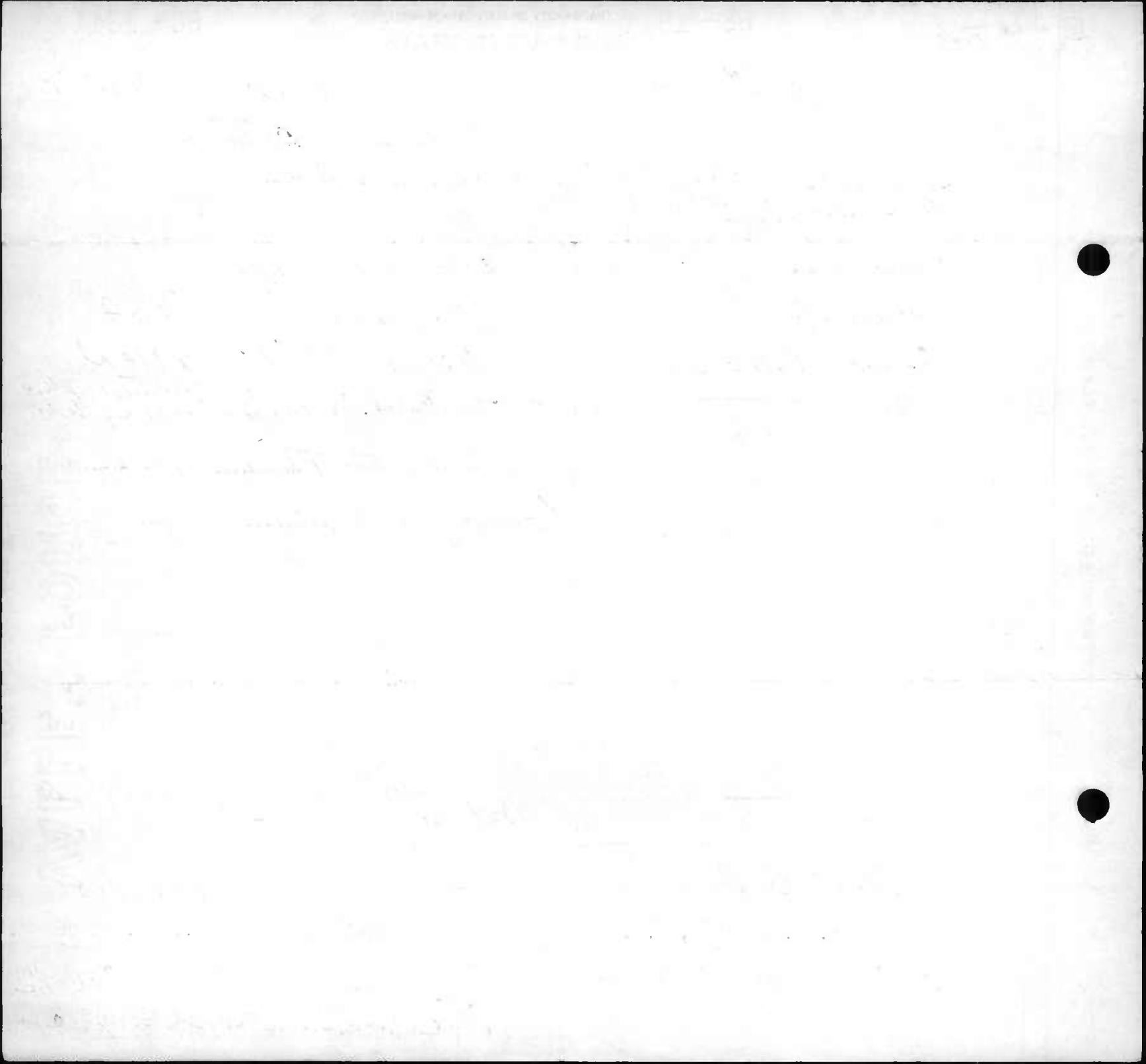
BIRTH NO.

1. NAME OF DECEASED (Type or Print) BERT O. ISNER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year February 2, 1968		Hour 3:42 A.M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 219 E. Cross St. (DOA)		3. DATE PRONOUNCED DEAD Month Day Year February 2, 1968		Hour 3:42 A.M.
5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland		B. COUNTY 2403		
6. SEX male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore
9. DATE OF BIRTH Oct 5, 1903		10. AGE (In years lost birthday) 64		E. STREET AND NUMBER 219 E. Cross St.
11. BIRTHPLACE (State or foreign country) WEST Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ULYSSES ISNER
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Millwright		14B. KIND OF BUSINESS OR INDUSTRY Lumber		15. MOTHER'S MAIDEN NAME RACHAEL ?
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE		17. SOCIAL SECURITY NO. ?		18. INFORMANT Robt Isner 34 Forest Ave SE. Massillon Ohio
19. 485X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Acute Bronchopneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED Emphysema and Cor Pulmonale		21. AUTOPSY? (Yes or No) Yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2/2/68				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 2-6-68		24C. NAME OF CEMETERY or CREMATORY Simpson's Arsonic
24D. LOCATION (City, town, or county) (State) Simpson W. Virginia		25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Geo. L. Schwab Funeral Home		
25D. ADDRESS Francis W. Miller 2101 Redbank				



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
E-43		68-1344		68-1344	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>Birdie Elliott</i>			11/22/68 9:15 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>House in the 5837 Bel Air Road Times Nursing Home Baltimore, Md.</i>			A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore Co</i>		
5. SEX <i>Female</i> 6. RACE <i>Cauc</i>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Summitt Ave 53-00</i>		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>			D. STREET ADDRESS (If rural, give location) <i>Rosedale</i>		
8. DATE OF BIRTH <i>8-24-1888</i>			9. AGE (In years last birthday) <i>79 yrs</i>		
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			13. FATHER'S NAME <i>George Patterson</i>		
14. MOTHER'S MAIDEN NAME <i>Margaret McMullen</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, unknown) (If yes, give war or dates of service) <i>No</i>		
16. SOCIAL SECURITY NO. <i>Unknown</i>			17. INFORMANT <i>Mrs. Mabel Ervin, 3305 Kentucky Ave. Baltimore, Md.</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>444.24 1250.9</i>			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) <i>Acute Mesenteric Thrombosis</i> 1 1/2 hours		
ANTECEDENT CAUSES			(B) <i>Generalized Arteriosclerosis</i> years		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>450.9 II</i>			<i>Diabetes mellitus</i> years		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <i>No</i>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (the hospital) attended the deceased from <i>9/27/1967</i> to <i>1/22/1968</i> , that (I) (we) last saw the deceased alive on <i>1/22/1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Albert B. Bradley</i>			23B. DATE SIGNED <i>1/23/68</i>		
23C. PHYSICIAN'S NAME (Type) <i>Albert. B. Bradley, M.D.</i>			23D. ADDRESS <i>4900 Belair Road Balto., Md. 21206</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>1/25/68</i>		
24C. NAME of CEMETERY or CREMATORY <i>Asbury Cemetery</i>			24D. LOCATION (City, town, or county) (State) <i>Port Deposit-Lenal-Cecil-Md</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>FEB 5 1968</i>			25B. NAME OF REGISTRAR <i>Albert E. Gaskins</i>		
25C. FUNERAL DIRECTOR <i>Lee A. Patterson & Son, Pimlico, Md.</i>			25D. ADDRESS		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1345

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 1345

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CIFALDO KATHERINE MARIE

2. DATE AND HOUR OF DEATH

1/30/68-6:20 PM

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNIVERSITY OF MARYLAND HSP
BALTIMORE

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD B. COUNTY Cecil

PORT DEPOSIT, Md

C. CITY OR TOWN

Cecil Co

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

E. STREET AND NUMBER

57-00

5. SEX

F

6. RACE

Caucasian

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

9/22/20

9. AGE (In years last birthday)

47

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Samuel ~~Wheeler~~ Wheeler

14. MOTHER'S MAIDEN NAME

MARIE ~~WHEELER~~ EMMA Bowersox

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

-

17. INFORMANT

CHAR T

ADDRESS

18. 396.01

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

VENTRICULAR TACHYCARDIA 30 mins

(B) DUE TO, OR AS A CONSEQUENCE OF:

AORTIC AND MITRAL VALVE DISEASE 20 years

(C) DUE TO, OR AS A CONSEQUENCE OF:

RHEUMATIC HEART DISEASE 25 years

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

CARDIAC THROMBOSIS, CEREBRAL EMBOLUS 3 days

19A. DATE OF OPERATION

1/26/68 + 1/27/68

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

VALVULAR HEART DISEASE

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from

that (I) (we) last saw the deceased alive on 1/30/68

19 68 to 1/30 19 68, and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Frederick S. Leary

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED

1/30/68

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

2-3-1968

24C. NAME OF CEMETERY OR CREMATORY

Brookview Cemetery

24D. LOCATION

Resing, Md.

25A. DATE REC'D BY HEALTH DEPT.

FEB 3 1968

25B. NAME OF REGISTRAR

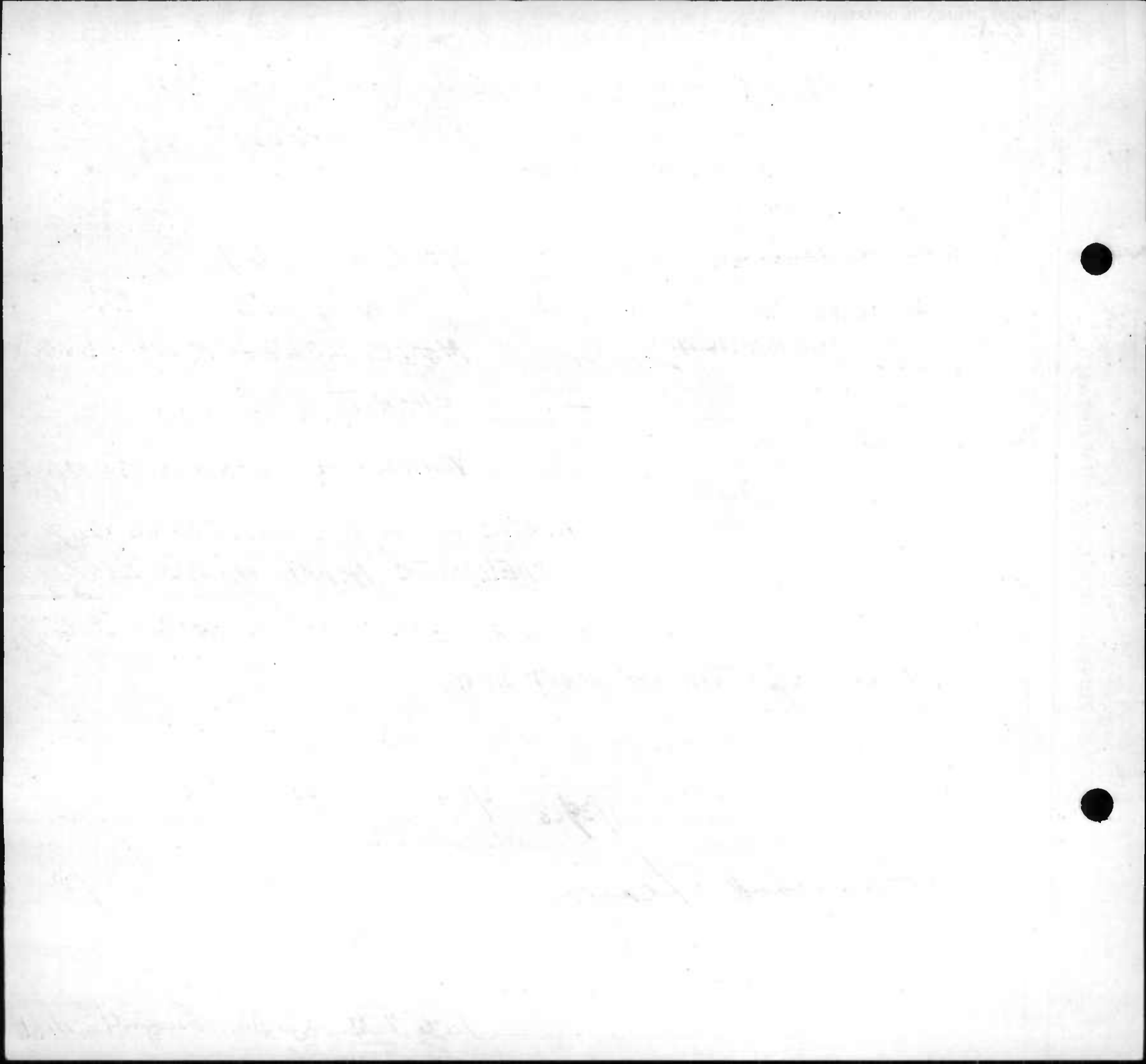
Robert E. Taylor

25C. FUNERAL DIRECTOR

Lee D. Patterson

ADDRESS

Don Perryville, Md



68- 1346

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 1346

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE H. JONES

2. DATE OF DEATH Known ☒ Month Day Year Hour
Estimated ☐ 1 17 68 8:15 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1606 Pennsylvania Ave.

3. DATE PRONOUNCED DEAD Month Day Year Hour
January 17, 1968 8:15 a.m.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland B. COUNTY

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS

YES ☒ NO ☐

6. SEX

Male

7. RACE

Colored

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

Dec. 22, 1909

10. AGE (In years lost birthday)

58?

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1606 PENNSYLVANIA AVE.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF

U.S.A.

13. FATHER'S NAME

William Jones

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Rebecca ?

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT

Richard L. Myers Sr. Clarksville Md

ADDRESS

19.

150 X I

CAUSE OF DEATH

Carcinoma of the esophagus

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) _____

DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

MEDICAL CERTIFICATION

150 X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S

NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 17, 1968

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1-29-68

24C. NAME of CEMETERY or CREMATORY

Balto. National

24D. LOCATION (City, town, or county)

Catonsville, Md.

25A. DATE REC'D BY HEALTH DEPT.

FEB 5 1968

25B. NAME OF REGISTRAR

Robert F. Surmon

25C. FUNERAL DIRECTOR

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68-1347 CERTIFICATE OF DEATH

REG. NO. 68-1347

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CHARLES SANDERSON		1-30-68 4:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL 33				A. STATE MARYLAND	
				B. COUNTY ANNE ARUNDEL COUNTY	
C. CITY OR TOWN DEALE				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER Box 96				52-00	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-10-14	9. AGE (In years lost birthday) 53	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mgr. - Restaurant		10B. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Wash., D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ELWOOD SANDERSON			14. MOTHER'S MAIDEN NAME Dorothy PEARL LUCKETT		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 579-38-7090	17. INFORMANT Mrs. Dorothy M. Sanderson (above address)		
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Heart failure 3 hr	
				(B) MYOCARDIAL INFARCTION 3 hr	
				(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 4-20-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 1/24 1968 to 1/30 1968, that (1) (we) lost saw the deceased alive on 1/30 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas C. Butler				23B. DATE SIGNED 1/30/68	
23C. PHYSICIAN'S NAME (Type) THOMAS C. BUTLER				23D. ADDRESS 601 N. Broadway	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/2/68		24C. NAME OF CEMETERY or CREMATORY Baltimore Nat. Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968			
25B. NAME OF REGISTRAR R. E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Nalley's Funeral Home Inc., Mt. Rainier, Md.			

YT 100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-1348

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>James E. Shilling</u>		2. DATE AND HOUR OF DEATH <u>2/2/68</u> <u>5 46</u> A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland Gen. Hosp.</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>Carroll Co.</u> <u>56-00</u>	
5. SEX <u>MALE</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>03-31-89</u> 9. AGE (In years last birthday) <u>78</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>VICE-PRESIDENT OF CANNING COMPANY</u>				11. BIRTHPLACE (State or foreign country) <u>Md. CARROLL CO</u>	
13. FATHER'S NAME <u>Thomas R. Shilling</u>				14. MOTHER'S MAIDEN NAME <u>MARY ELIZABETH HAIFLEIGH</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>217-28-5675</u>				16. SOCIAL SECURITY NO. <u>217-28-5675</u>	
17. INFORMANT ADDRESS <u>HOSPITAL RECORDS</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
18. <u>410.91/85X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <u>Coronary Thrombosis</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic heart disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF <u>Hypertension</u> (C) <u>CA of prostate</u> <u>Carcinoma of prostate, widespread metastases</u>					
19. DATE OF OPERATION <u>2</u> 20. AUTOPSY? (Yes or No) <u>Yes</u> 21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>21</u> 22. I certify that (I) (this hospital) attended the deceased from <u>1/29/68</u> 19 to <u>2/2/68</u> 19 that (I) (we) lost saw the deceased alive on <u>2/2/68</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ralph D. Raymond MD</u> 23B. DATE SIGNED <u>2/2/68</u> 23C. PHYSICIAN'S NAME (Type) <u>Ralph D. REYMOND</u> 23D. ADDRESS <u>Maryland Gen. Hosp.</u>					
24A. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u> 24B. DATE <u>2/5/68</u> 24C. NAME of CEMETERY or CREMATORY <u>CARROLLTON CH. OF GOD CEMETERY</u> 24D. LOCATION (City, town, or county) (State) <u>FINNSBURG RD #1 MD.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 5 1968</u> 25B. NAME OF REGISTRAR <u>Ralph E. Jankovic</u> 25C. FUNERAL DIRECTOR ADDRESS <u>J. E. Meyers Jr. Westminster, Md.</u>					

August 1899 and 1900

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1349

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 1349

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mary Gray

2. DATE AND HOUR OF DEATH

February 3, 1968 12:50 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

90 Gould Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE Virginia

B. COUNTY King George

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☐ NO ☒

E. STREET AND NUMBER

Rt. 2 Box 290

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

16 Mar. 1885

9. AGE (In years lost birthday)

82

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

Own home

11. BIRTHPLACE (State or foreign country)

King George Co. Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Alexander Totts

14. MOTHER'S MAIDEN NAME

Mary Cakley

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

229/60/3243T

17. INFORMANT

Mrs. Browning (daughter)

ADDRESS

18.

412.9 + 1250.9

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Immediate Cause: Cerebral Vascular Thrombosis

(B) Antecedent Cause: Arteriosclerotic C-V disease
Uncomplicated diabetes mellitus

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

3 weeks

15 yrs

422.1

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

Cerebral Concussion (Jan 10, 1968)

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 18 1968 to Feb. 3 1968, that (I) (we) last saw the deceased alive on February 2 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.

23A. SIGNATURE

H. V. Harbold M.D.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

Feb. 3, 1968

23C. PHYSICIAN'S NAME (Type)

H. V. HARBOLD M.D.

23D. ADDRESS

4706 HARFORD ROAD BALTIMORE Md.

24A. BURIAL REMOVAL (Specify)

Burial

24B. DATE

2/5/68

24C. NAME OF CEMETERY or CREMATORY

Oakland Cemetery

24D. LOCATION

King George Co. Va.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

Robert P. Paine

ADDRESS

Singleton Funeral Home, Glen Burnie, Md.

Handwritten text, possibly a signature or name, appearing in the center of the page.

Handwritten text at the bottom of the page, including what appears to be a date and possibly a location or address.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1350

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 1350

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ANTHONY OETTL

2. DATE AND HOUR OF DEATH

January 31, 1968

6:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 3215 Chesterfield Ave.
Baltimore, Md., 21213

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY
Md., 21213

C. CITY OR TOWN
Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

3215 Chesterfield Ave.

5. SEX

male

6. RACE

white

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

3/11/05

9. AGE (In years
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Welder

10B. KIND OF BUSINESS OR INDUSTRY

Beth Steel Corp.

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOSEPH OETTL

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

213-09-3454

17. INFORMANT

ADDRESS

Margaret (nee Sichard) Oettl, wife, above

18.

412.9 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

Acute Congestive Heart Failure

(B)
DUE TO, OR AS A CONSEQUENCE OF:

Arteriosclerotic Cardiovascular Disease

(C)
DUE TO, OR AS A CONSEQUENCE OF:

1. Severe Acute Influenza Infection.
2. Severe Bronchial Asthma.

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At ☐ Not While
Work At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/31 1968 to 1/31 1968,
that (I) (we) last saw the deceased alive on 1/31 1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

L B Stevens MD

Attending
Phys. ☒

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

2/1/68

23C. PHYSICIAN'S
NAME (Type)

Dr. L. B. Stevens

23D. ADDRESS

3400 Erdman Ave.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

2/3/68

24C. NAME OF CEMETERY OR CREMATORY

Gardens of Faith Cem.

24D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

FEB 5 1968

25B. NAME OF REGISTRAR

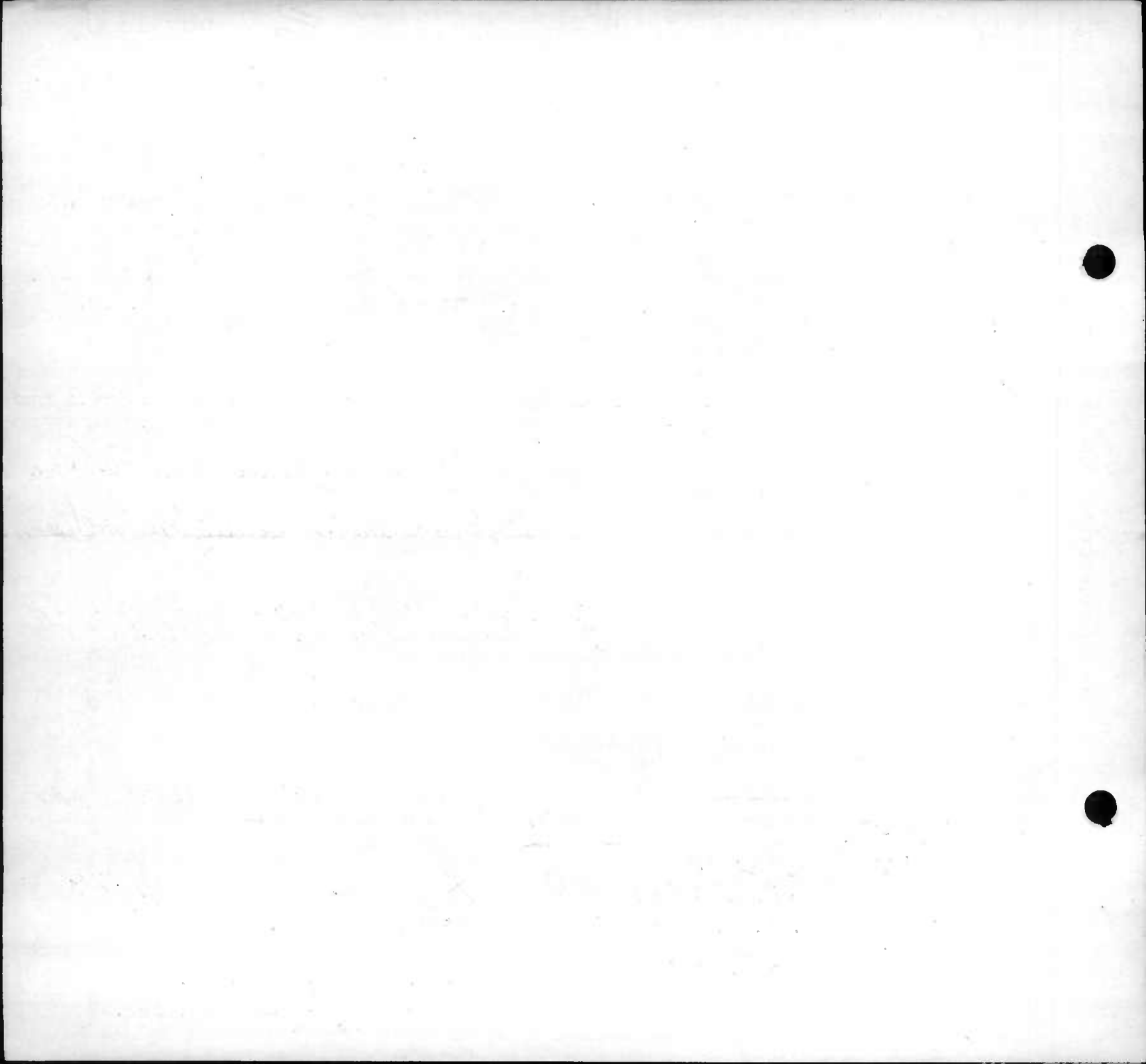
Robert E. Farber

25C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.

3331 Brehms Lane

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

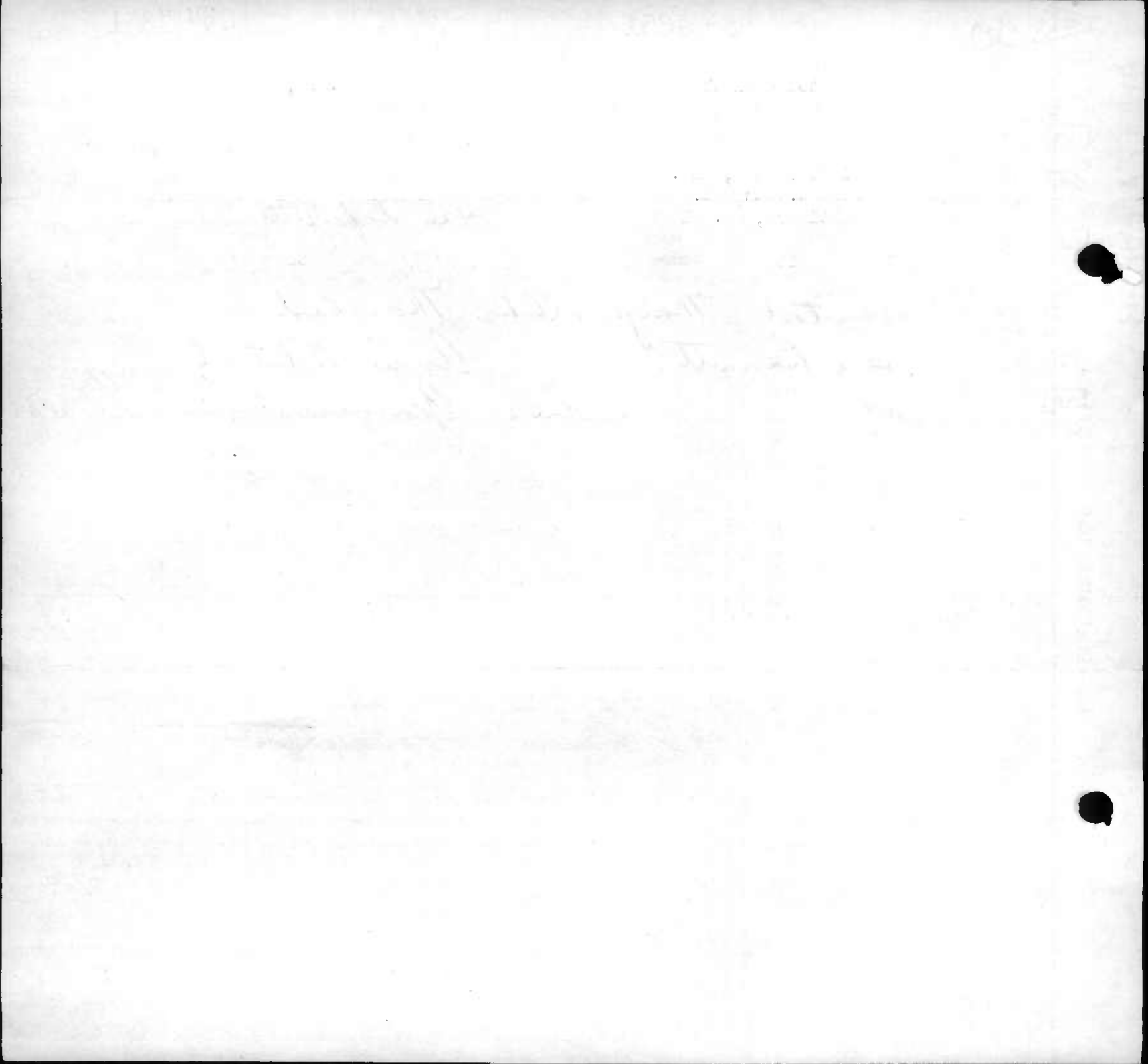
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1351

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 1351

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Peyton Bennett		2. DATE AND HOUR OF DEATH Jan. 21, 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 19-02		M.	
FULL NAME OF HOSPITAL OR INSTITUTION 90 Midtown Home, Inc. 808 St. Paul St. Baltimore, Md. 21202		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 426 Lafayette Ave					
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/17/79	9. AGE (In years last birthday) 88	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) accountant		10B. KIND OF BUSINESS OR INDUSTRY Maryland Club		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME John Bennett		14. MOTHER'S MAIDEN NAME Rene Milstead			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-01-1828 A		17. INFORMANT Georgiana Cameau ADDRESS Dyans Ave	
18. 412.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardio-Respiratory Failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute Congestive Failure Arteriosclerotic CVD Semipermanent		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 422.1 II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 1 19 65 to Jan 21 19 68 , that (I) (we) last saw the deceased alive on Jan 21 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Willard Appleford DEGREE				23B. DATE SIGNED 1/23/68	
23C. PHYSICIAN'S NAME (Type) Willard Appleford MD DEGREE				23D. ADDRESS 6615 Reisterstown Rd.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-22-68		24C. NAME OF CEMETERY OR CREMATORY Swiss Hill Cemetery Laurel, Md	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR De Witt Donohue ADDRESS Laurel, Md	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-1352

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) ROGER HANBRICK		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> January 29, 1968		Hour 5:00 A.M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital		3. DATE PRONOUNCED DEAD Month Day Year January 29, 1968		Hour 5:00 A.M.
6. SEX Male		7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. DATE OF BIRTH 8-28-1936		10. AGE (In years last birthday) 31	11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Russell		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Burning School
15. MOTHER'S MAIDEN NAME Mary Kelly		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 215-32-3566
18. INFORMANT Mrs. Nellie Raut		19. CAUSE OF DEATH Hemomediastinum and left hemothorax		20. ADDRESS 618 S. Newkirk St
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) E821.1		22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. E819.4 II		23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24. DATE OF OPERATION 2		25. CONDITION FOR WHICH OPERATION WAS PERFORMED		26. AUTOPSY? (Yes or No) (Partial) Yes
27. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) highway		29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Baltimore National Pike West of Chapel Gate Lane
30. TIME OF INJURY (APPROX.) 1-29-68 2:55 A.		31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		32. HOW DID INJURY OCCUR? Passenger in auto-fixed object collision
33. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		34. ACTUAL SIGNATURE Charles S. Springate, M.D.		35. DATE SIGNED January 29, 1968
36. BURIAL CREMATION, REMOVAL (Specify) Burial		37. DATE 2-1-68		38. NAME OF CEMETERY or CREMATORY Woodlawn
39. DATE REC'D BY HEALTH DEPT. FEB 5 1968		40. NAME OF REGISTRAR Robert E. Johnson		41. FUNERAL DIRECTOR Thelma A. Hoffman
42. ADDRESS 3218 Hudson St.		43. ADDRESS 3218 Hudson St.		44. ADDRESS 3218 Hudson St.

1938-1939

8-28-1938

Thursell

Mr.

Learning State Highway

Mary Kelly

22-32-322 on Hillside Rd. 2nd 1st 1st

1/2

Concord, Mass. 01742

WALLACE

Mr.

Route 2-1-28 Woodland

State Office

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-1353 CERTIFICATE OF DEATH

REG. NO. 68-1353

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ELIZABETH KLASS

2. DATE AND HOUR OF DEATH

Jan. 30, 1968 10:20 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

711 S. Ellwood Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

md.

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

711 S. Ellwood Ave.

5. SEX

F

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

3-23-1847

9. AGE (In years last birthday)

100

If Under 1 Yr.

Months: Days

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Adam Hamer

14. MOTHER'S MAIDEN NAME

?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Miss Dora Klass

ADDRESS

711 S. Ellwood Ave.

18.

412.9 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ARTERIOSELENOTIC SV. DIS.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

10 + 11/2

MEDICAL CERTIFICATION

422.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9/30 1957 to 1/30 1968, that (I) (we) lost saw the deceased alive on 1/30 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Benjamin H. Hirschstein

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

1/31/68

23C. PHYSICIAN'S NAME (Type)

DR. B. H. HIRSCHSTEIN

23D. ADDRESS

171 S. HIGHLAND AVE BALD. 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

2-2-68

24C. NAME OF CEMETERY OR CREMATORY

Mt. Carmel

24D. LOCATION

md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

FEB 5 1968

25B. NAME OF REGISTRAR

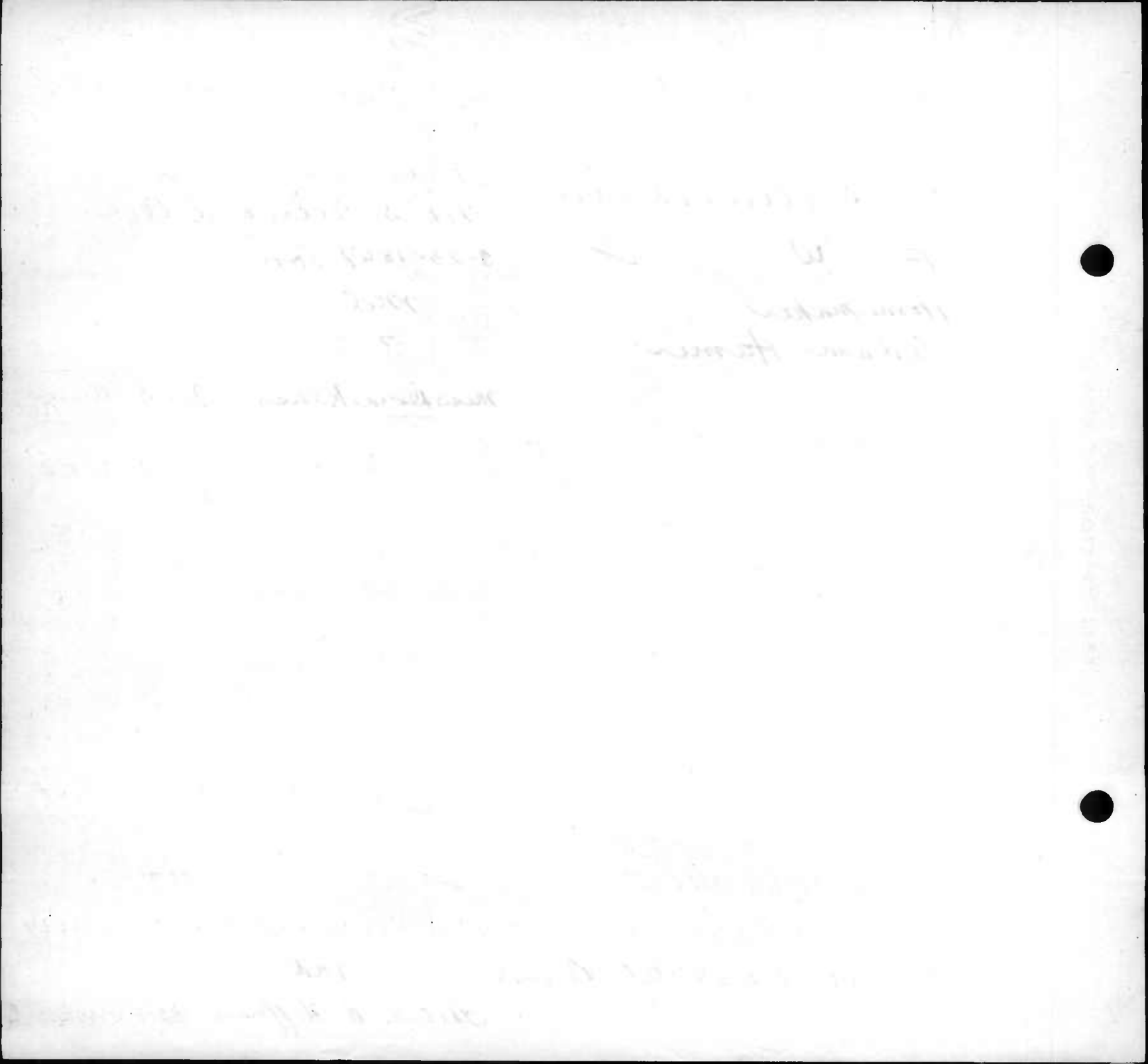
Robert E. Farber

25C. FUNERAL DIRECTOR

Thelma R. Hoffman

ADDRESS

3218 Hudson St.



68-1354 CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ERNST BERGER

GEORGE

M.

2. DATE AND HOUR OF DEATH

Feb 3 1968

11 30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)BALTIMORE CITY HOSPITALS
4940 Eastern Avenue, Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

3 MARYLAND

26-07

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

336 MARCON ST.

21224

5. SEX

MALE

6. RACE

ANGLO.

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

5-11-95

9. AGE (In years
last birthday)

72

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

MACHINIST

10B. KIND OF BUSINESS OR INDUSTRY

STEEL MFR.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

(?)

14. MOTHER'S MAIDEN NAME

(?)

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

213-07-3356

17. INFORMANT

Records: BCH-4940 Eastern Avenue 21224

ADDRESS

18.

441.9 I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Ruptured Aortic Aneurysm

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

Feb 3-68

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED

Ruptured Aortic Aneurysm

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED

IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb 3 1968 to Feb 3 1968,
that (I) (we) last saw the deceased alive on Same 2/3/ 19 68 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

D.R. Morrow M.D.

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

Feb 3 68

23C. PHYSICIAN'S
NAME (Type)

D.R. Morrow

DEGREE

23D. ADDRESS

BALTIMORE CITY HOSPITALS
4940 Eastern Avenue, Baltimore, Maryland 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

2/4/68

24C. NAME OF CEMETERY or CREMATORY

MORELAND MEM.

24D. LOCATION

(City, town, or county)

BALTO. CO. Md

(State)

25A. DATE REC'D BY HEALTH DEPT.

FEB 5 1968

25B. NAME OF REGISTRAR

Robert E. Taylor

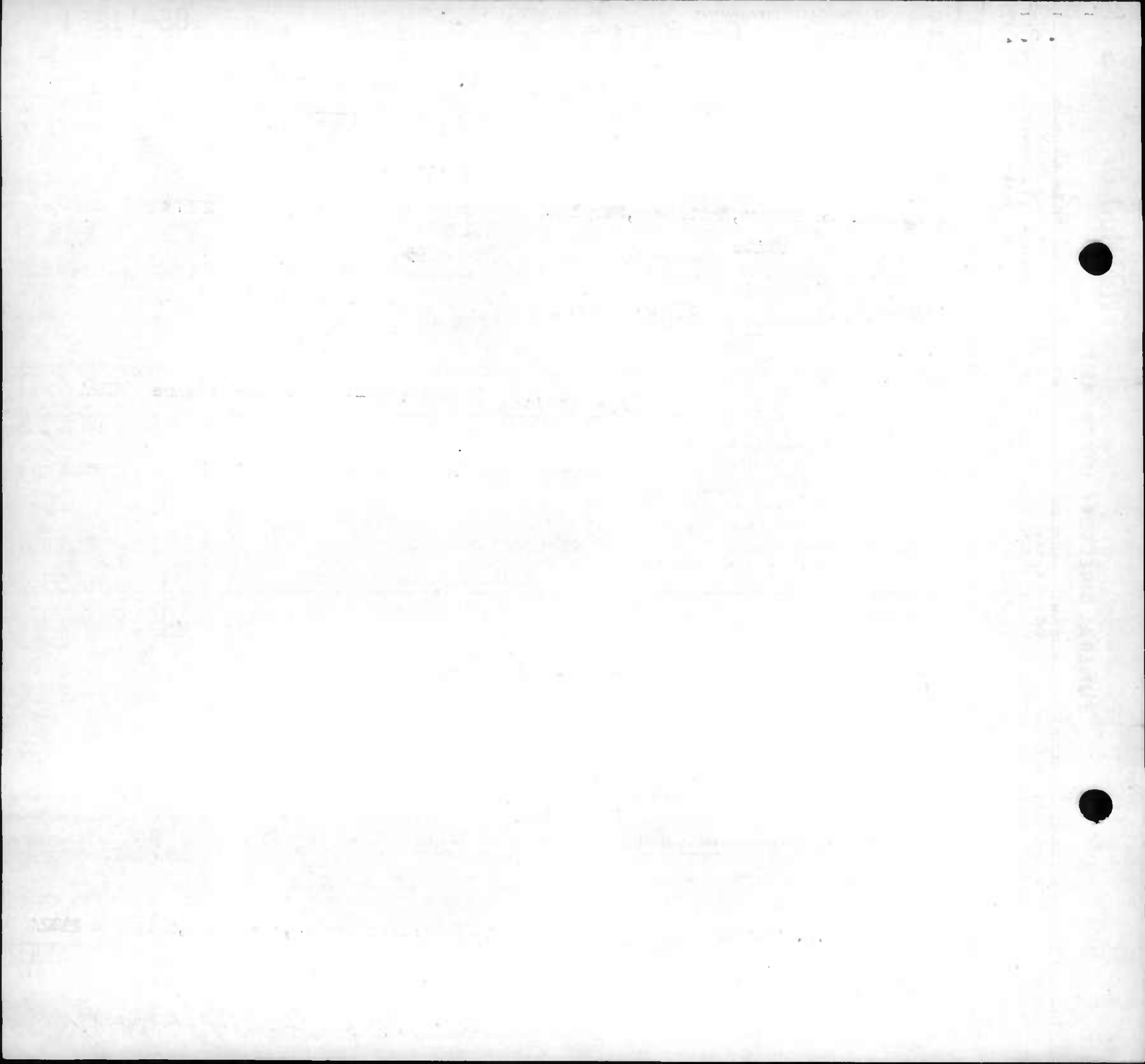
25C. FUNERAL DIRECTOR

W. Bruce Penally, Herdolph, Md

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

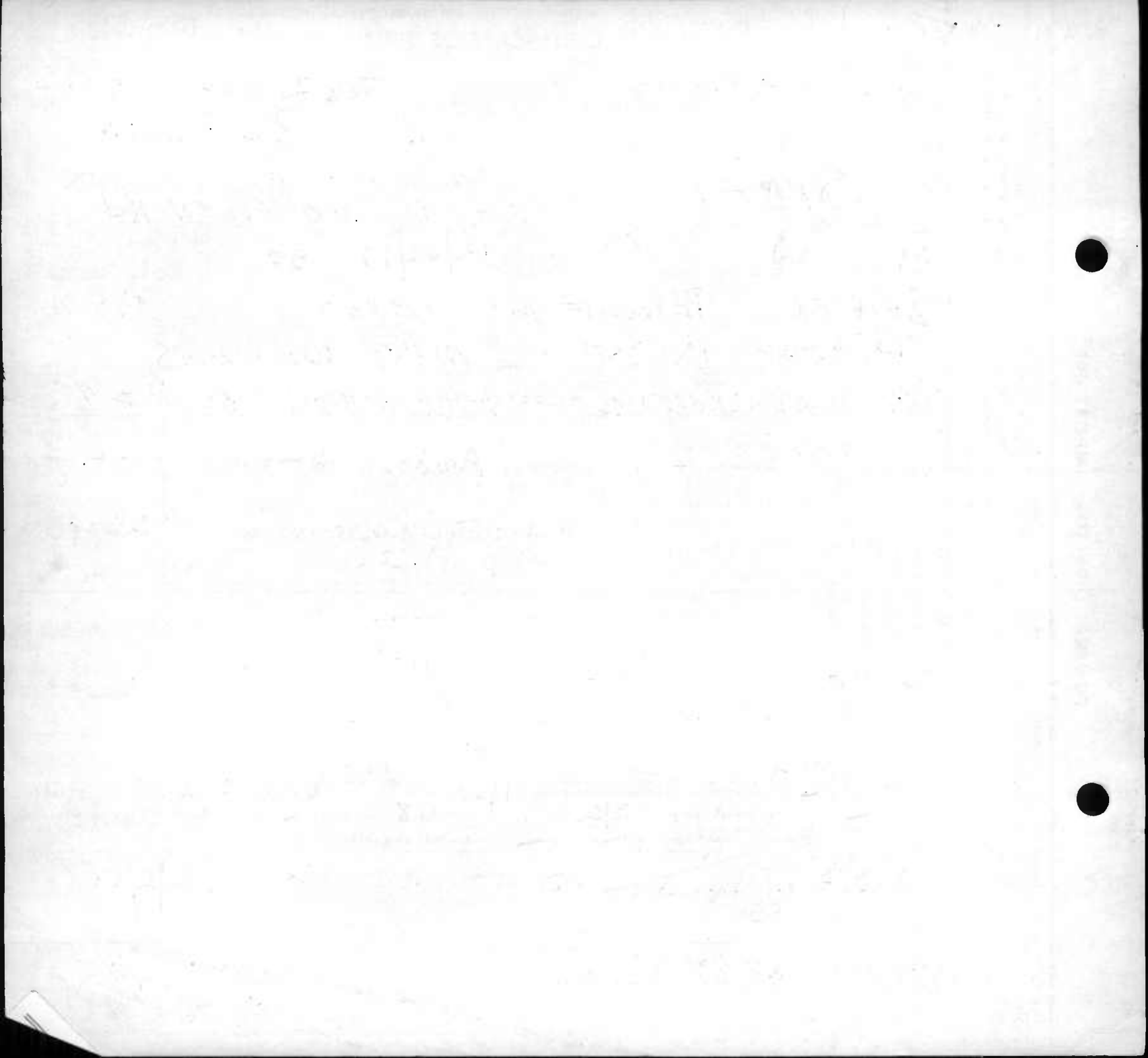
FUNERAL DIRECTOR: IMPORTANT



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 68-1355		REG. NO. 68-1355	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) <u>William G. Probst</u>				2. DATE AND HOUR OF DEATH <u>Feb 2 1968</u> <u>5:04 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>42 SINAI</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u> 53-00 C. CITY OR TOWN <u>RANDALLSTOWN</u> D. INSIDE CITY LIMITS? <u>NO</u> E. STREET AND NUMBER <u>P.O. Box 300 ALLEN Rd</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/22/17</u>	9. AGE (In years lost birthday) <u>50</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>PETROLEUM</u>		11. BIRTHPLACE (State or foreign country) <u>TEXAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE PROBST</u>				14. MOTHER'S MAIDEN NAME <u>MARY WILLIAMS</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes/no or unknown) (If yes, give war or dates of service) <u>YES WWII + KOREA</u>		16. SOCIAL SECURITY NO. <u>46-09-3320</u>		17. INFORMANT ADDRESS <u>LORENE M. PROBST - AS IN # 4</u>			
18. <u>1835-X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Acidosis, metabolic</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Metastatic carcinoma of prostate</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>2 1/2 yrs</u>			
19. DATE OF OPERATION <u>NA</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NA</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NA</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>NA</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>NA</u>			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u>NA</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <u>NA</u>		21F. HOW DID INJURY OCCUR? <u>NA</u>			
22. I certify that <u>(this hospital)</u> attended the deceased from <u>1/23</u> 19 <u>68</u> to <u>2/2</u> 19 <u>68</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>2/2</u> 19 <u>68</u> and that in <u>(my)</u> <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> <u>(did not)</u> view the body after death.							
23A. SIGNATURE <u>[Signature]</u> MD				23B. DATE SIGNED <u>2/2/68</u>		23C. PHYSICIAN'S NAME (Type) <u>[Signature]</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u>				24B. DATE <u>2/3/68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 5 1968</u>				25B. NAME OF REGISTRAR <u>W. Brooks Proddy, Hurdick, Md.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>[Signature]</u>	

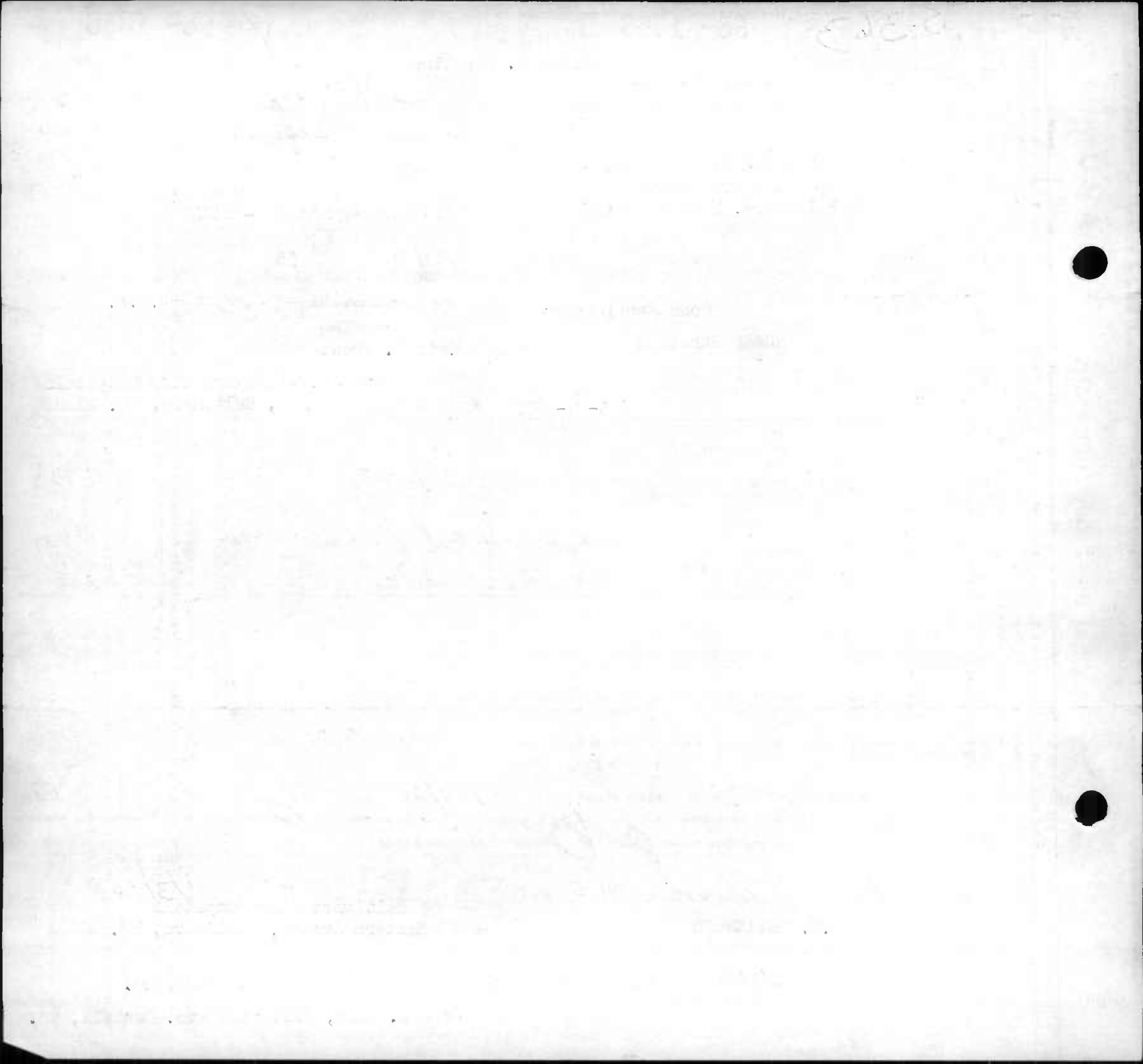


51-05-25 1
IW

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-363		68-- 1356		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 1356	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		William M. Stratton STRATTON, WILLIAM		2. DATE AND HOUR OF DEATH 1/31/68 1:05 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224				A. STATE MARYLAND		B. COUNTY BALTIMORE C 53-00	
				C. CITY OR TOWN Dundalk		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 8340 Kavanagh Road - 21222			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/23/09		9. AGE (In years last birthday) 58	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		10B. KIND OF BUSINESS OR INDUSTRY Codd Fabricators		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RUBEN Stratton				14. MOTHER'S MAIDEN NAME Ocie T. Trent			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 241-07-7039		17. INFORMANT RECORDS: Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224			
18. 303.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE Sepsis DUE TO, OR AS A CONSEQUENCE OF: (B) Bacterial pneumonia DUE TO, OR AS A CONSEQUENCE OF: (C) pleuritis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 2 days 20 yrs	
19. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED II		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/29/68 19 68 to 1/31 19 68, that (I) (we) last saw the deceased alive on 1/31 19 68 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE E. M. Levinsohn, M.D.				23B. DATE SIGNED 1/31/68			
23C. PHYSICIAN'S NAME (Type) E.M. LEVINSOHN				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/3/68		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR John J. Duda		25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		ADDRESS	



K-350

68-1357

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-1357

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

KEATON, WADE A

2. DATE AND HOUR OF DEATH

FEB 15, 1968

8 25 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

11 South Arlington Avenue

21223

5. SEX

Male

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

9-7-1907

9. AGE (In years
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.

Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Followers Supply Co.

11. BIRTHPLACE (State or foreign country)

W. Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Mack Keaton

14. MOTHER'S MAIDEN NAME

Virginia Keaton

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no at unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

227-10-6087

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue 21224

18. 011.9

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Pneumonia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

TBC

(C)

CVA

002.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

SAME

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 14 1967 to Feb 15 1968
that (I) (we) lost saw the deceased alive on Feb 15 1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Naeh Brandes M.D.

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

FEB 15, 1968

23C. PHYSICIAN'S
NAME (Type)

Jack Brandes

DEGREE

23D. ADDRESS

Baltimore City Hospitals

4940 Eastern Avenue, Baltimore, Md. 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

2/15/68

24C. NAME OF CEMETERY or CREMATORY

Green Haven Cem.

24D. LOCATION

(City, town, or county)

(State)

Green Haven Md.

25A. DATE REC'D BY HEALTH DEPT.

FEB 5 1968

25B. NAME OF REGISTRAR

John J. Falcus

25C. FUNERAL DIRECTOR

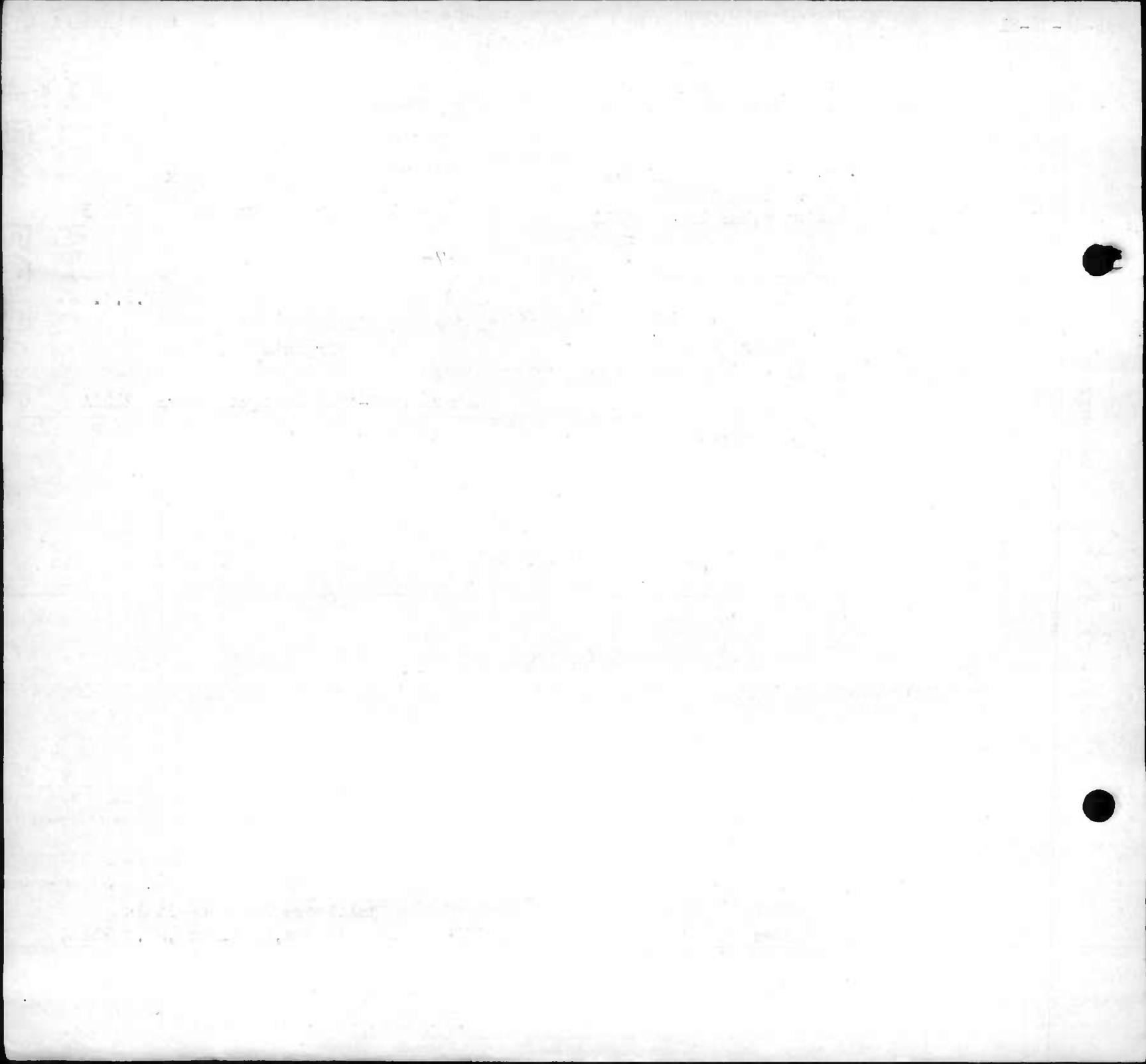
John J. Falcus & Son Inc.

ADDRESS

981 Hollins St. Balt. Md.

FUNERAL DIRECTOR: IMPORTANT

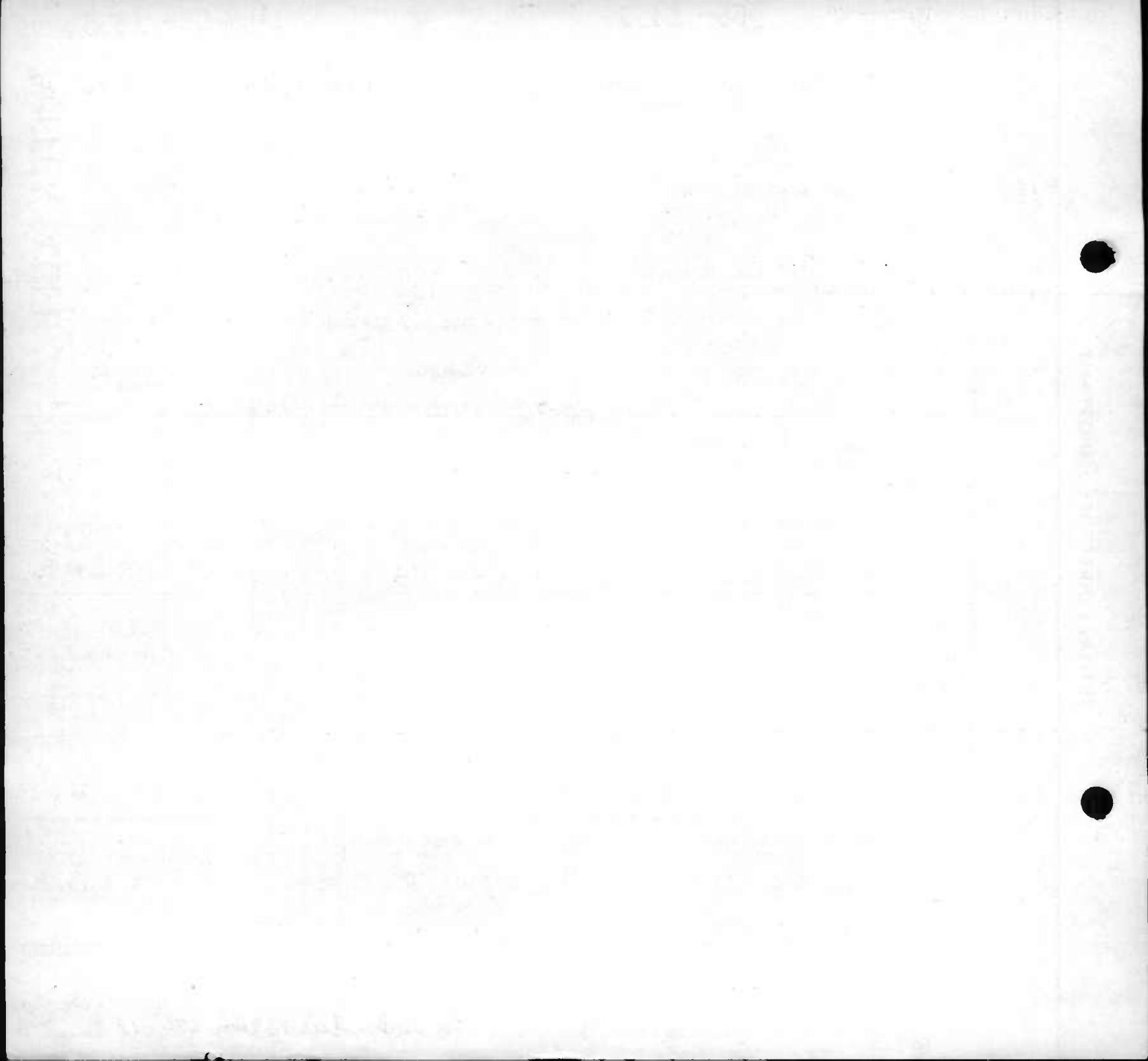
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1358			
1. NAME OF DECEASED (Type or Print) MARGARET ROOT				2. DATE AND HOUR OF DEATH FEB 2, 1968 9:20 P.M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 26-34							
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				C. CITY OR TOWN BALTIMORE				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX FEMALE				6. RACE WHITE				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY Housewife				9. AGE (In years lost birthday) 5-22-80 87			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME GEORGE EHRHARDT				14. MOTHER'S MAIDEN NAME MARY Cavey							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 217-09-0175D				17. INFORMANT RECORDS-BCH-4940 EASTERN AVENUE-BALTIMORE			
18. 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) SHOCK ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. SEPSIS ACVA				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: SHOCK (B) DUE TO, OR AS A CONSEQUENCE OF: SEPSIS (C) ACVA				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day. 3 days. 3 weeks.			
19A. DATE OF OPERATION 331X II				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1-9 19 68 to 2-2- 19 68 , that (I) (we) last saw the deceased alive on 2-2- 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Jack Brandes M.D.				23B. DATE SIGNED FEB 2, 1968							
23C. PHYSICIAN'S NAME (Type) DR. JACK BRANDES				23D. ADDRESS BCH-4940 EASTERN AVENUE, BALTIMORE, MD							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 2-6-1968				24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery			
24D. LOCATION Baltimore Co.				24E. STATE Md.							
25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968				25B. NAME OF REGISTRAR Robert E. Farkner				25C. FUNERAL DIRECTOR Lasschmidt Funeral Home 7401 Belair Rd			



FUNERAL DIRECTOR: IMPORTANT

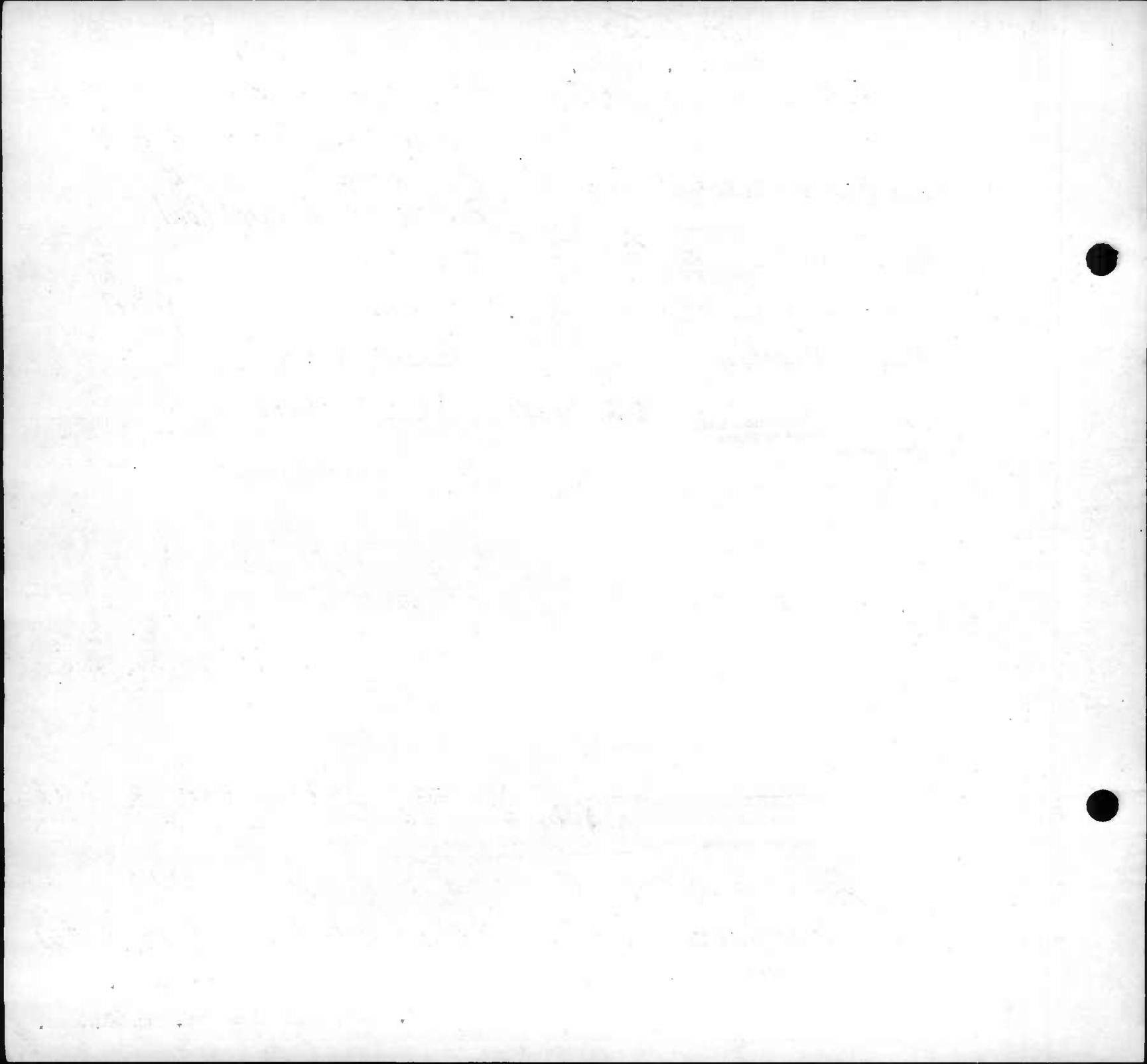
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1359

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-1359

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Gilbert C. Barr Sr.		2. DATE AND HOUR OF DEATH 2-2-68 4:05 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD North Charles General Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN Edgemere D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION North Charles General Hospital		E. STREET AND NUMBER Box 263 A. Dogwood Road		F. ZIP CODE 53-00	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-6-1895	9. AGE in years (last birthday) 72	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Tinner		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.		11. BIRTHPLACE (State or foreign country) Texas	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Barr, Martin		14. MOTHER'S MAIDEN NAME Grant, Mary	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-07-0281		17. INFORMANT NCAH. chart	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 432.91 + 162.1		CAUSE OF DEATH Coronary artery occlusion		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARTERIO SCLEROSIS			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: Healed myocardial infarct			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 452X II		(C) Coronary artery disease, Nephrosclerosis & Atherosclerosis		6 M	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED yes	
20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input type="checkbox"/>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <input type="checkbox"/>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from Jan. 22 1968 to Feb. 2 1968 , that (I) (we) last saw the deceased alive on Feb. 2 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Luis E. Rengel				23B. DATE SIGNED 2/2/68	
23C. PHYSICIAN'S NAME (Type) Jose Martinez		23D. ADDRESS M.D. Medical Arts Bldg. Balto. 21201			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/5/68		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.			



1
R-100

68-1360

BALTIMORE CITY HEALTH DEPARTMENT

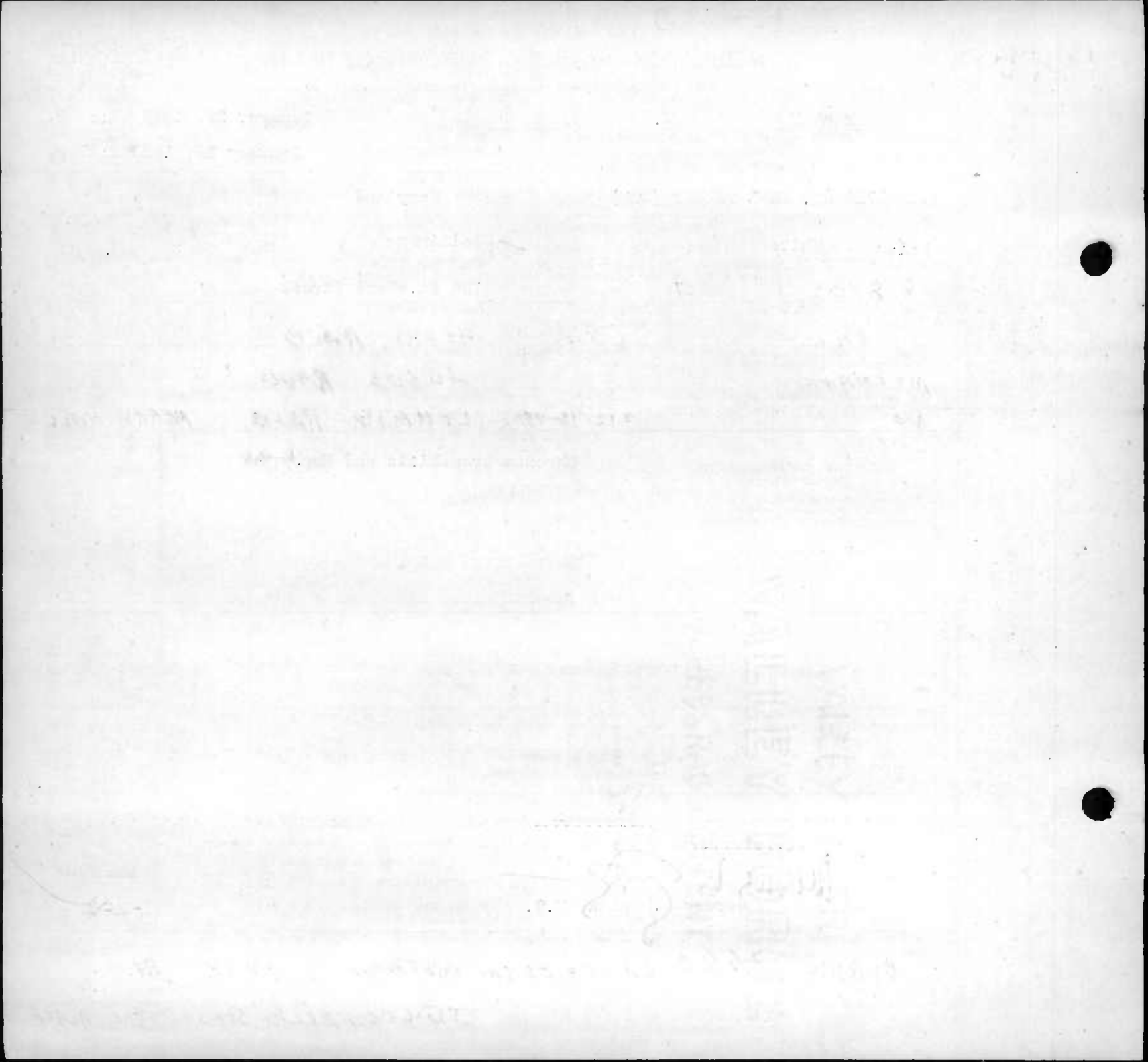
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-1360

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) STEWART W. RAUB		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> January 29, 1968 9:17 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 001734 ST. PAUL STREET (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour January 29, 1968 9:17 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 6/8/03		10. AGE (In years lost birthday) 64	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 212-16-4874	
15. MOTHER'S MAIDEN NAME AGNES RAUB		18. INFORMANT ADDRESS LEHMAN RAUB PERRY HALL	
19. 491 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Chronic Bronchitis and Emphysema (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) No	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: [Signature] M.D. EXAMINER'S NAME (Type): Werner J. Spitz M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 1-30-68			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 2/1/68	
24C. NAME OF CEMETERY or CREMATORY CHURCH OF THE BRETHREN		24D. LOCATION (City, town, or county) YORK PA.	
25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		25B. NAME OF REGISTRAR [Signature]	
25C. FUNERAL DIRECTOR J.D. CONNELLY SONS		ADDRESS 300 MACE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1361

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 1361

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

LUTHER E. LOOKADOO

2. DATE AND HOUR OF DEATH

January 30, 1968 @ 10 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

90

HOUSE OF PINES

5837 BELAIR RD

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

BALTO

MD.

BALTO

53-00

C. CITY OR TOWN

ESSEX

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

361 EMDSLEIGH

5. SEX

male

6. RACE

white

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

3/28/80

9. AGE (In years last birthday)

88

If Under 1 Yr.

Months: Days: Hours: Min.

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

RETIRED

11. BIRTHPLACE (State or foreign country)

M.C.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

UNK

16. SOCIAL SECURITY NO.

248-03-1833

17. INFORMANT

LUTHER P. LOOKADOO

ADDRESS

ABOVE

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cancer of Prostate

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Arteriosclerotic Heart Disease

(C)

DUE TO, OR AS A CONSEQUENCE OF:

Coronary Heart Disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Aug 1 1961 to Jan 29 1968, that (I) (we) last saw the deceased alive on Jan 29, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Irving R Beck M.D.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

January 31, 1968

23C. PHYSICIAN'S NAME (Type)

IRVING R BECK

M.D.

23D. ADDRESS

901 Funderburg Baltimore Md. 21220

24A. BURIAL CREMATION, REMOVAL (Specify)

REMOVAL

24B. DATE

1/31/68

24C. NAME of CEMETERY or CREMATORY

UNITE CEM

24D. LOCATION

(City, town, or county)

(State)

FORT MILL S.C.

25A. DATE REC'D BY HEALTH DEPT.

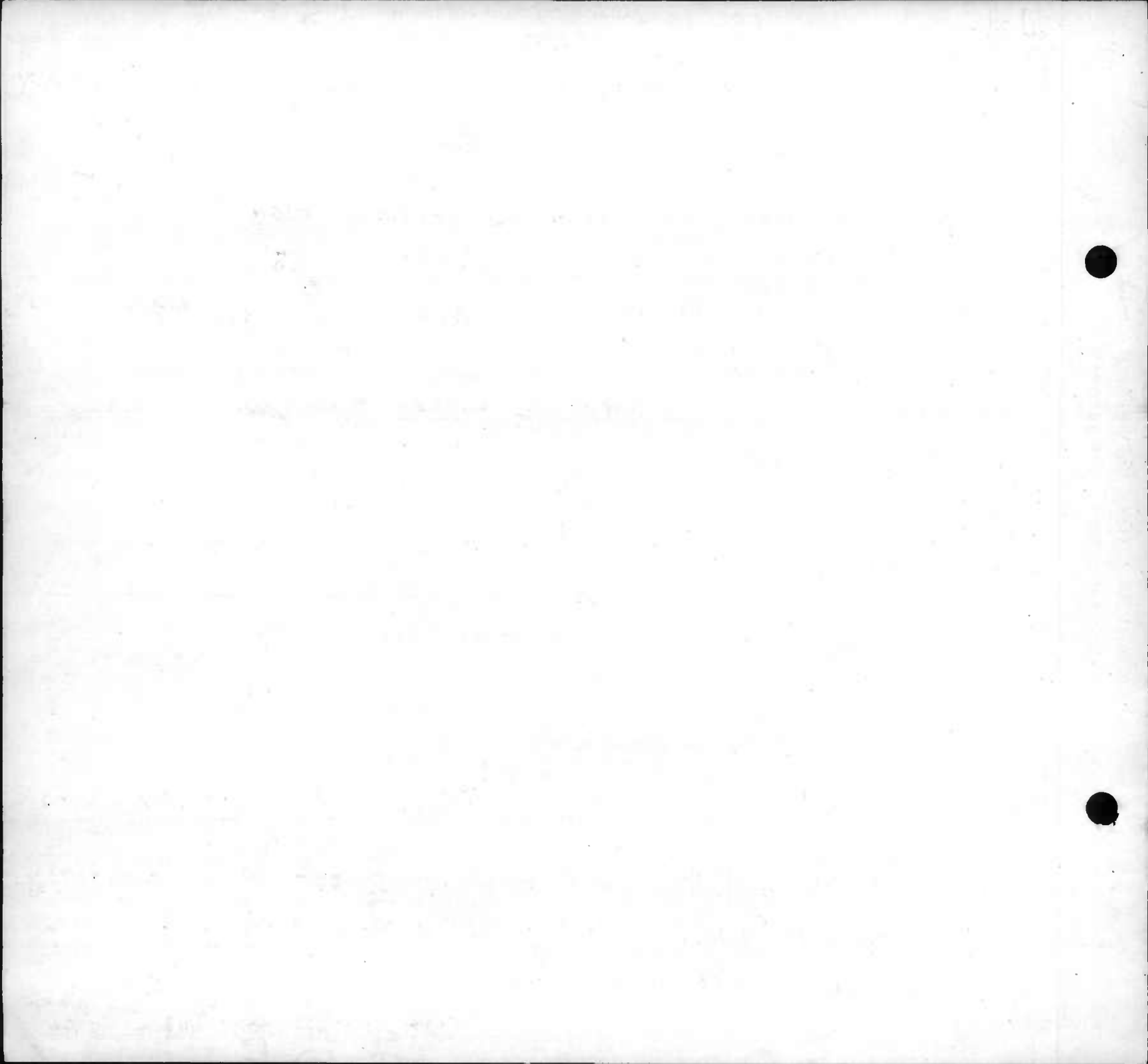
FEB 5 1968

25B. NAME OF REGISTRAR

Robert E. Jenkins

25C. FUNERAL DIRECTOR ADDRESS

J.G. CONNELLY 300 MA CE WOLFE FT. FORT MILL S.C.



1
S-410

68- 1362 BALTIMORE CITY HEALTH DEPARTMENT

68- 1362

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RICHARD THOMAS SELPH		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> February 3, 1968 1:10 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00811 CLINTWOOD CT. (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour February 3, 1968 1:10 A. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 25-01 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH Oct. 25, 1905		10. AGE (In years lost birthday) 62 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed		14B. KIND OF BUSINESS OR INDUSTRY Boatman	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME Alice Hooker		18. INFORMANT ADDRESS Mr. George R. Selph 4350 6th Street 21225	
19. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Bronchopneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Cancer of Lung		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 2-3-68 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/6/68	
24C. NAME of CEMETERY or CREMATORY Glen Haven		24D. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Feb 5 1968	
25C. FUNERAL DIRECTOR McCully F. H.		ADDRESS 237 Patapsco Ave. 21225	

MALIBU V. OF OAK

EXCELLENCE

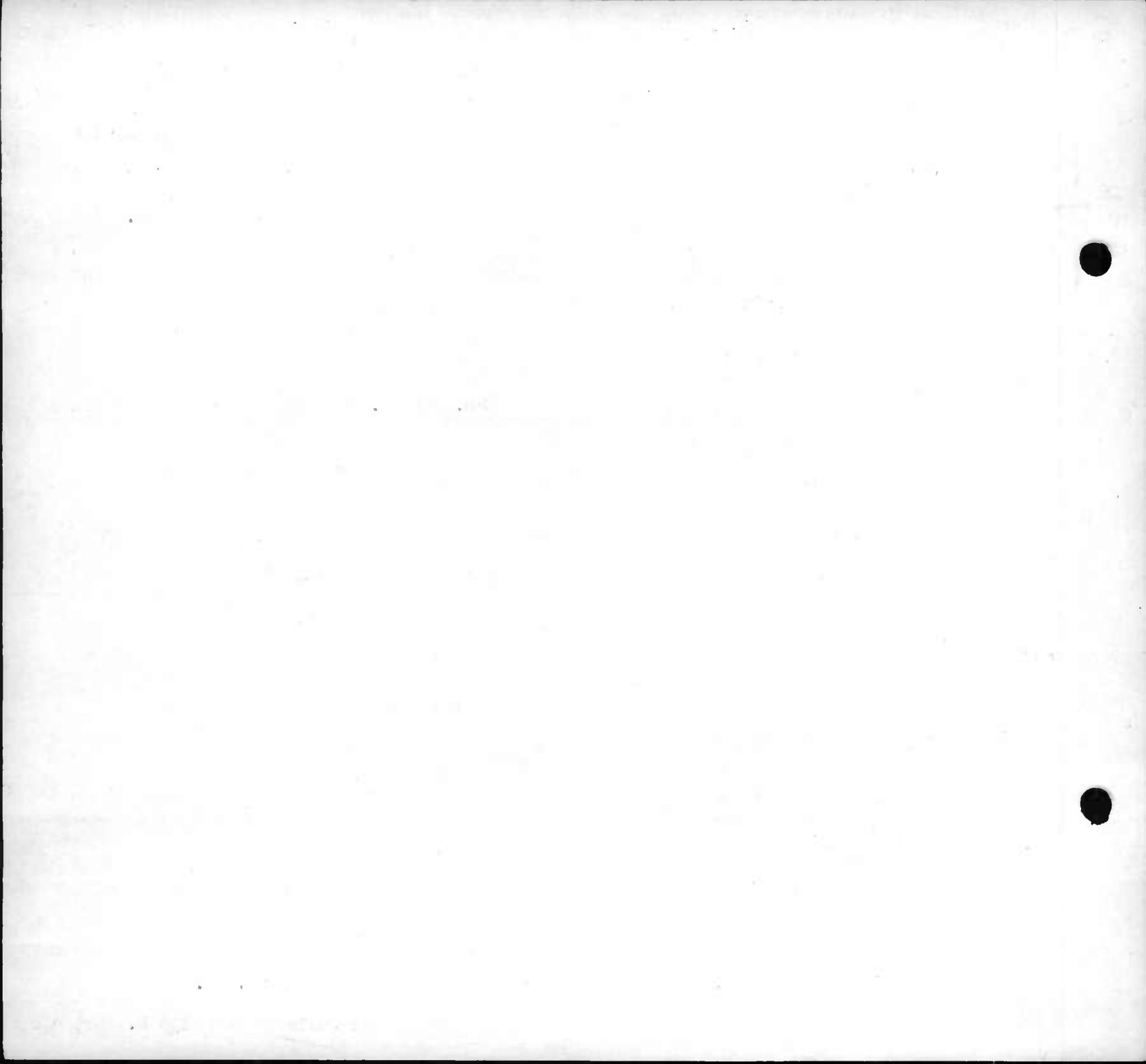
1950

1950

1950

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

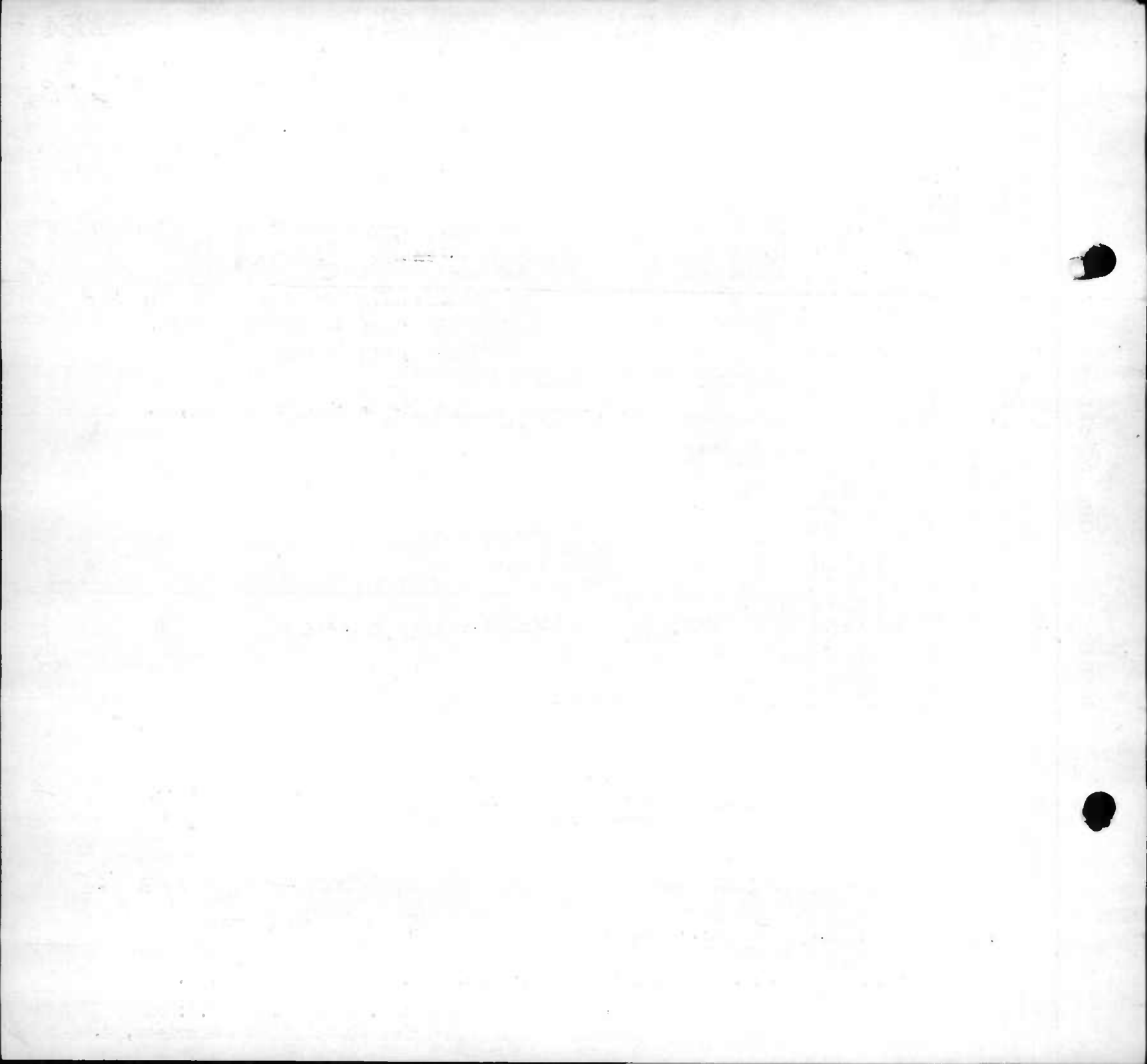
68-1363		BALTIMORE CITY HEALTH DEPARTMENT		68-1363	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) John A. GARLAND			2. DATE AND HOUR OF DEATH 2-2-68 4:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1407 William St.		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/24/94	9. AGE (In years last birthday) 73 yrs	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Electrician		10B. KIND OF BUSINESS OR INDUSTRY Electrical		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John GARLAND			14. MOTHER'S/MAIDEN NAME Mary PETTY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes #1		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. John J. Garland	
				ADDRESS Same	
18. 188X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Heart failure and Uremia Metastasis Cancer of bladder			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months		
18. 181.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 11-29-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca. of bladder		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-26-67 1967 to 2-2 1968 , that (I) (we) last saw the deceased alive on 2-2 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Garland				23B. DATE SIGNED 2-2-68	
23C. PHYSICIAN'S NAME (Type) Jose G. Amayo				23D. ADDRESS Bon Secours Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2 5 68		24C. NAME OF CEMETERY OR CREMATORY Cathedral	
24D. LOCATION (City, town, or county) (State) Balto. Md.					
25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Mc Cully	
				ADDRESS 130 E. Fort Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-1364</u>
BIRTH NO. <u>68-1364</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>JULIUS STRAUS</u>		2. DATE AND HOUR OF DEATH <u>1/31/68</u> <u>9 25</u> / <u>P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>SINAI HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4907 CORDELIA AVE</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/24/91</u>	9. AGE (In years last birthday) <u>76</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Painter</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Joseph Straus</u>		
14. MOTHER'S MAIDEN NAME <u>Rosalie Eichstetter</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		
16. SOCIAL SECURITY NO. <u>217-16-8210A</u>		17. INFORMANT ADDRESS <u>Bert Straus 7909 Brookhaven, Rd.</u>		
18. <u>486 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CARDIO-RESPIRATORY ARREST</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>PNEUMONIA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. <u>493 X II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>PARKINSON'S DISEASE</u>				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>1/8</u> 19 <u>68</u> to <u>1/31</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1/31</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Thomas P. Smith</u>		23B. DATE SIGNED <u>1/31/68</u>		
23C. PHYSICIAN'S NAME (Type) <u>THOMAS P. SMITH</u>		23D. ADDRESS <u>SINAI HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Feb. 2nd 68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Chevera Ahavas Chesed Cem.</u>
24D. LOCATION (City, town, or county) (State) <u>Randallstown, Md.</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 5 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Falcione</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Sylvan S. Lewis & Son P.O. Box 65</u> <u>Memorial Chapel Garrison, Md.</u>



D-548 68-1365 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. **68-1365**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) WILLIAM DONALDSON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour February 1, 1968 3:35 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour February 1, 1968 3:35 P.M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 12-04	
6. SEX male	7. RACE negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 10-12-1916		10. AGE (In years lost birthday) 52		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		E. STREET AND NUMBER 214 E. 23rd Street	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		14B. KIND OF BUSINESS OR INDUSTRY B. & O. RAILWAY		15. MOTHER'S MAIDEN NAME MARY SMITH	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 705-12-3287		18. INFORMANT THOMAS DONALDSON ADDRESS 5003 READY AVE.	
19. 412.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 2/2/68 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 2-6-68		24C. NAME of CEMETERY or CREMATORY ARBUTUS MEM. PARK	
24D. LOCATION (City, town, or county) (State) ARBUTUS Md.		25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		25B. NAME OF REGISTRAR Robert E. Jackson	
25C. FUNERAL DIRECTOR JOSEPH KNIGHT		25D. ADDRESS 1639 N. BROADWAY			

WALLER

RECEIVED

WALLER

N-100

68- 1366

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 1366

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) LAWRENCE NEFF		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> January 29, 1968		Hour 10:45 A.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital		3. DATE PRONOUNCED DEAD Month Day Year January 29, 1968		Hour 10:45 A.
6. SEX Male		7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH AUG 27, 1938		10. AGE (In years last birthday) 29	11. BIRTHPLACE (State or foreign country) BALTIMORE, Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME LAURENCE L. NEFF		
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK MECHANIC		15. MOTHER'S MAIDEN NAME CATHERINE KERN		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 212-36-289		18. INFORMANT Mrs. CATHERINE NEFF
19. E9551X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshot wound of head		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1840 Wilhelm Street
22D. TIME OF INJURY (APPROX.) 1-29-68 7:30 A.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? -Undetermined Apparently shot self
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>				
ACTUAL SIGNATURE Charles S. Springate		M.D. Charles S. Springate, M.D.		DATE SIGNED January 29, 1968
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE FEB 2, 1968		24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL CEM.
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR RAYMOND J. CURRAN		
25D. ADDRESS 817 S. CARLETT DR. TOWSON, MD 21204				

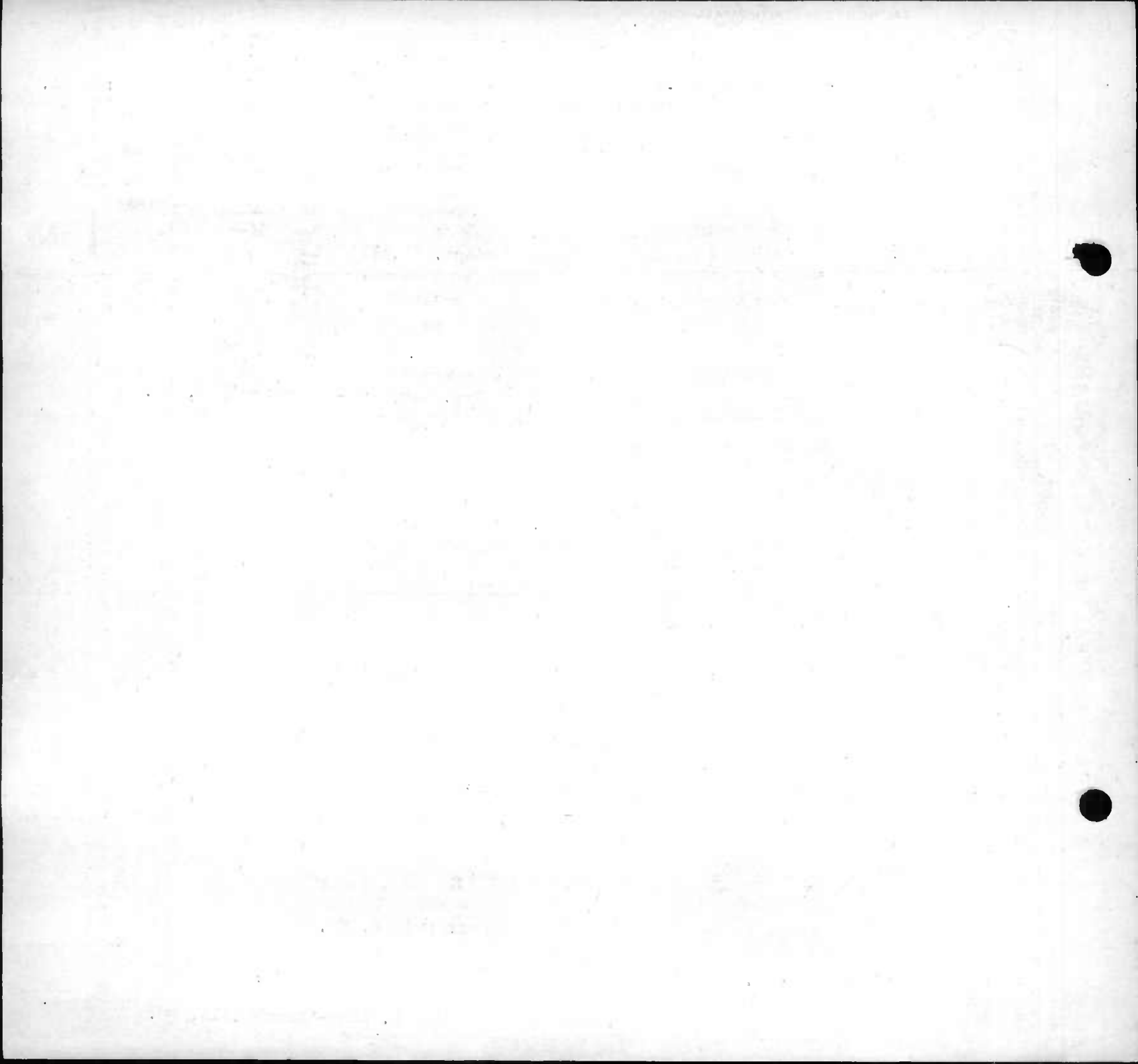
Letter from M.E.'s office

3-20-68

M.H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		68-1367		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		68-1367	
1. NAME OF DECEASED (Type or Print) Harvey Melvin Gardner				2. DATE AND HOUR OF DEATH January 23, 1968 9:15 A. M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Queen Anne's C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER Stevensville, Queen Anne, Maryland					
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 12, 1913		9. AGE (In years last birthday) 54 yrs		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10B. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Gardner				14. MOTHER'S MAIDEN NAME King					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Gardner - Stevensville, Md.			
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerosis				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Moments	
19. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 2-15 1967 to 1-24 1968 , that (I) (we) last saw the deceased alive on 1-12 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Ralph Libby				23B. DATE SIGNED 2-1-68				23C. PHYSICIAN'S NAME (Type) Ralph Libby	
23D. ADDRESS Grasonville, Md.				23E. DATE SIGNED 2-1-68					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan. 25		24C. NAME OF CEMETERY OR CREMATORY Kingsley Church Yard		24D. LOCATION (City, town, or county) (State) Chester, Maryland			
25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		25B. NAME OF REGISTRAR Edgar L. Lane		25C. FUNERAL DIRECTOR ADDRESS Edgar L. Lane-Church Hill, Md.					



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 1368

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

TIMOTHY C. DONNELLY

2. DATE
OF
DEATHKnown ☒Estimated ☐

Month

Day

Year

Hour

February 2, 1968

8:00 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

40 ST. AGNES HOSPITAL

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

February 2, 1968

8:00 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Howard

6. SEX

Male

7. RACE

White

8. MARRIED ☐NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Simpsonville

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

March 31, 1951

10. AGE (In years
last birthday)

17

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

13 Westwood Drive

11. BIRTHPLACE (State or foreign country)

Balto.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James F. Donnelly

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

14B. KIND OF BUSINESS OR INDUSTRY

Student (High School)

15. MOTHER'S MAIDEN NAME

Betty Muck

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

James F. Donnelly, Simpsonville, Md.

19. E 812.1 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Multiple Traumatic Injuries

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

E 816.4 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)
Street

22C. WHERE DID (If in Baltimore City, give exact location)

INJURY OCCUR? Old Columbia Road 600' South
of entrance of Columbia22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

2

2

1968

1:15

P

m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Passenger in auto-auto collision

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

2-3-68

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

2-6-68

24C. NAME OF CEMETERY or CREMATORY

Crest Lawn Cemetery

24D. LOCATION (City, town, or county)

(State)

Merritsville, Md.

25A. DATE REC'D BY HEALTH DEPT.

FEB 5 1968

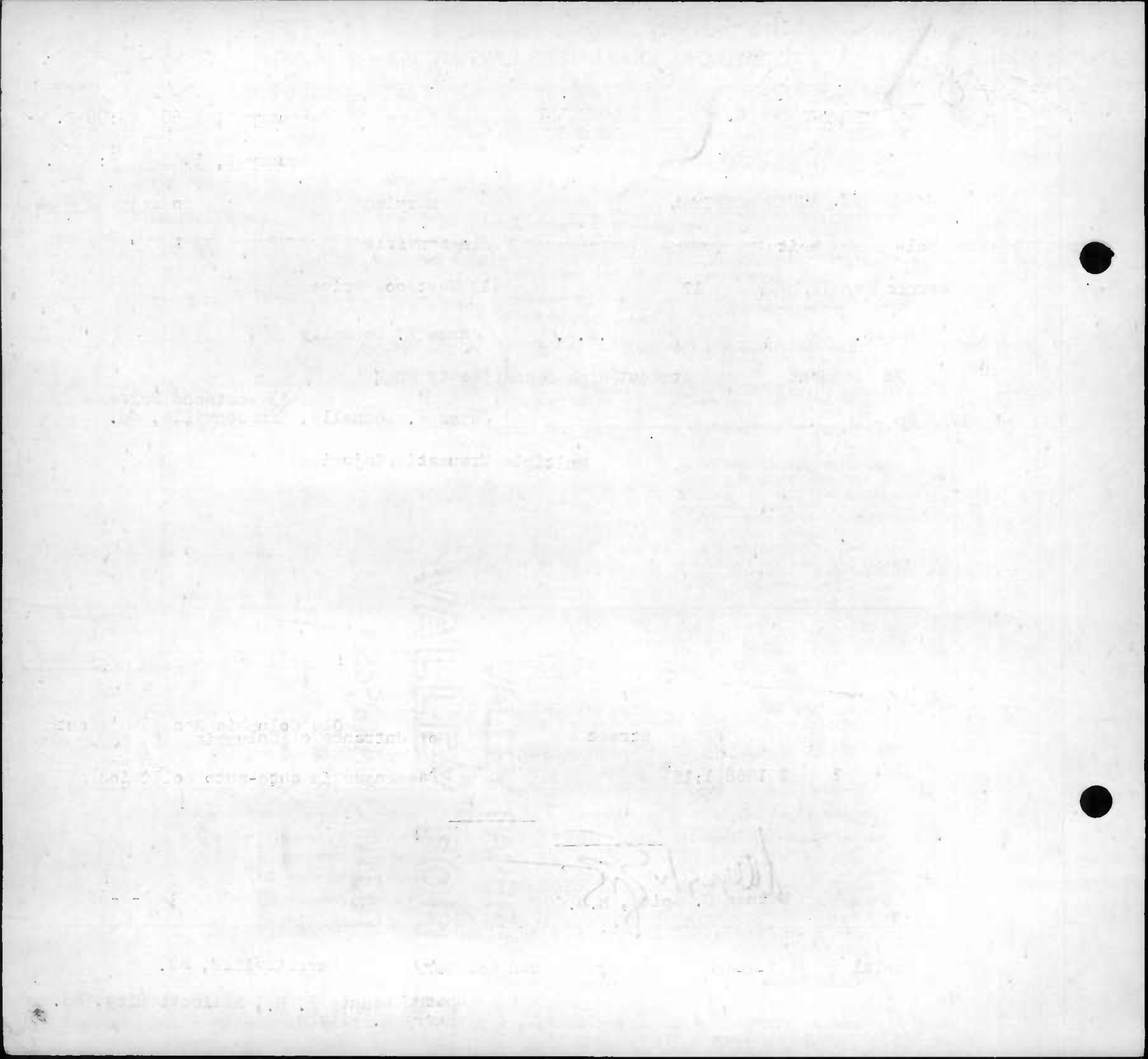
25B. NAME OF REGISTRAR

Robert E. Spitz

25C. FUNERAL DIRECTOR

Howard County F. H., Ellicott City, Md.
Harry H. Witzke

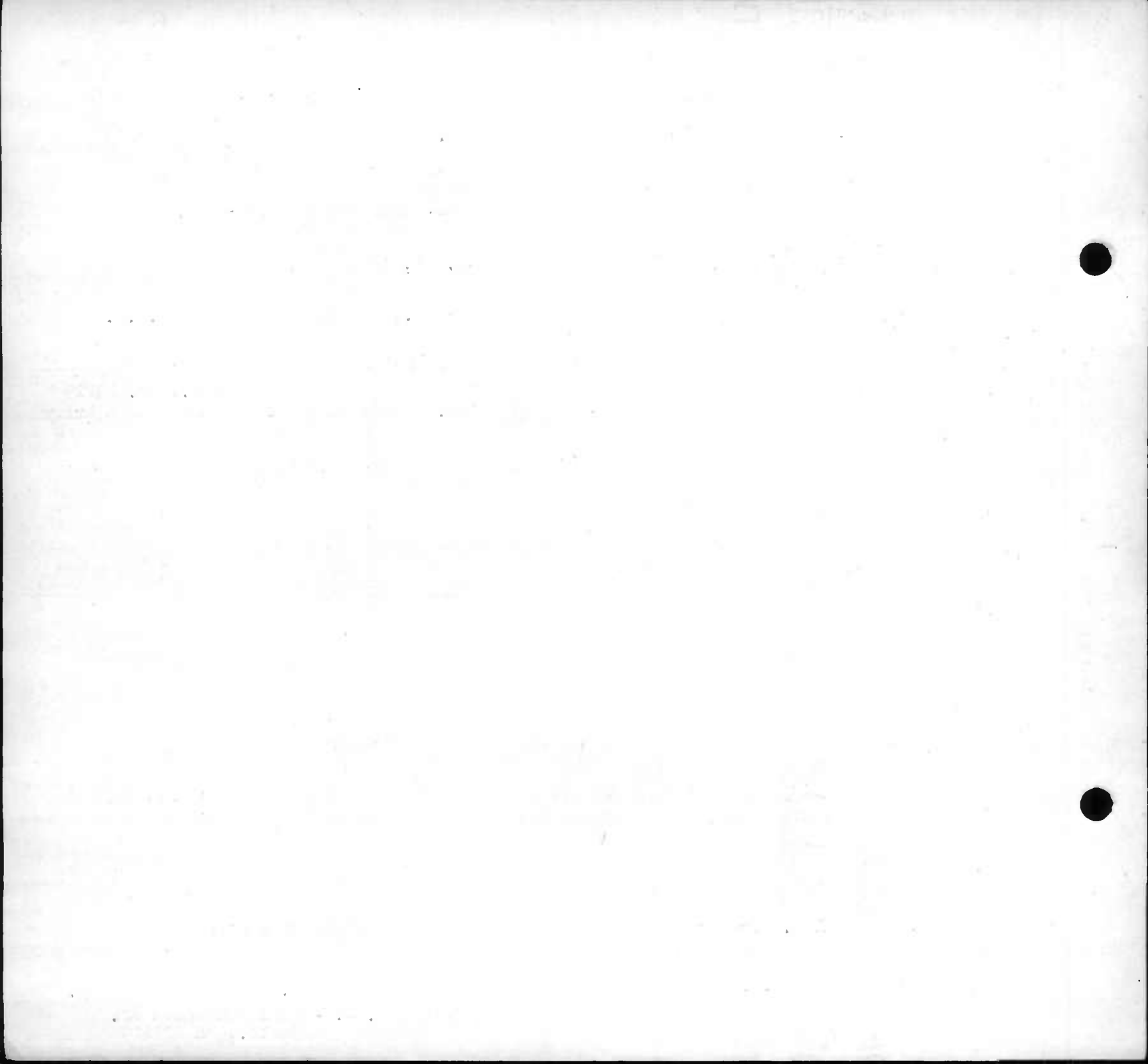
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-1369</u>
BIRTH NO. <u>B-215</u>		68-1369 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Edward Leroy Buxbaum		2. DATE AND HOUR OF DEATH February 2, 1968 <u>1:45</u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION 514 Glen Allen Drive - Apt/D		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX M		6. RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH Mar. 21, 1890 9. AGE (In years last birthday) 77
13. FATHER'S NAME Joseph Buxbaum		14. MOTHER'S MAIDEN NAME Mary Smith		11. BIRTHPLACE (State or foreign country) Balto., Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-03-0301		17. INFORMANT Mrs. Edward Buxbaum, 514 Glen Allen Drive ADDRESS Balto., Md. 21229
18. <u>153.0</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE CARCINOMA, CAECUM 11 MONTHS DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. <u>153.0</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>2/24</u> <u>1968</u> to <u>2/2</u> <u>1968</u> , that (I) (we) last saw the deceased alive on <u>1/30/68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Paul R. Ziegler</i>		23B. DATE SIGNED <u>2/3/68</u>		23C. PHYSICIAN'S NAME (Type) Paul R. Ziegler
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-5-68		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		
25B. NAME OF REGISTRAR <i>R. E. Salas</i>		25C. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Av. Balto., Md. 21229		



FUNERAL DIRECTOR: IMPORTANT

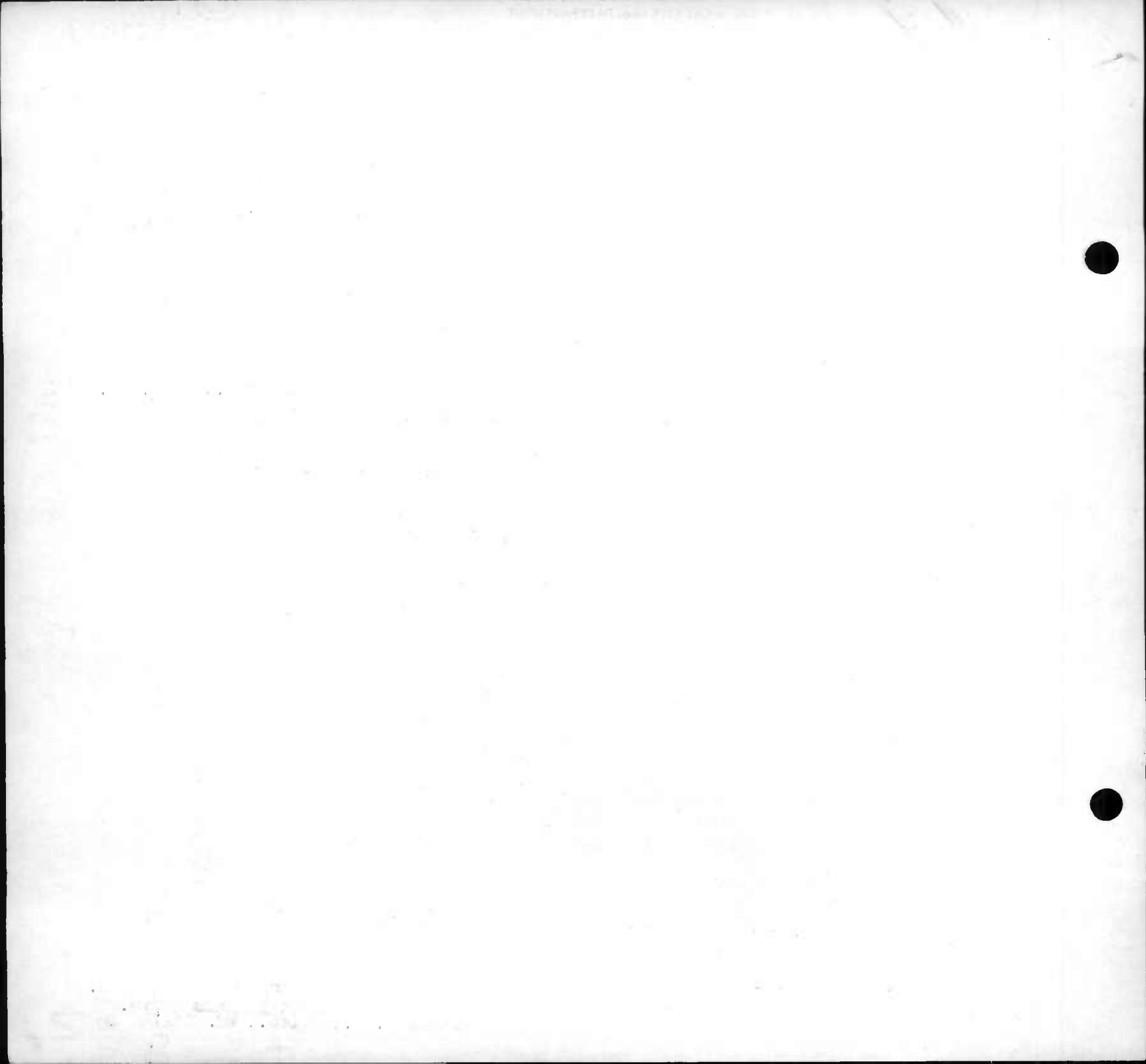
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1370

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 1370

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MILLER, WILMER, C.		2. DATE AND HOUR OF DEATH 2. 3. 68 6.00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSPITAL OF MARYLAND.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY C. CITY OR TOWN BALTIMORE INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4014 Cranston Avenue.	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1. 22. 03	9. AGE (In years last birthday) 65 yrs.	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Adam Miller			
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 214014158A		17. INFORMANT 4014 Cranston Ave., Balto., Md. 21229 Carrie (Wife) Same			
18. 412.7 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio-respiratory Failure (B) ACUTE CARDIAC DECOMPOSITION 6 hrs. (C) ASCVD. + CVA. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 2. 3. 19 68 to 2. 3. 19 68 , that (1) (we) last saw the deceased alive on 2. 3. 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Sheeren MD DEGREE				23B. DATE SIGNED 2. 3. 68.	
23C. PHYSICIAN'S NAME (Type) SHEREEN, S. SHEIKH MD DEGREE				23D. ADDRESS LUTHERAN HOSPITAL, Balto. MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-6-68		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore County Md.		25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968			
25B. NAME OF REGISTRAR Robert E. Taylor, MD		25C. FUNERAL DIRECTOR 4101 Edmondson Ave. Witzke F. D., Balto., Md. 21229			



68- 1371

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 1371

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) HENRY PFAFF		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 505 N. Curly Street		3. DATE PRONOUNCED DEAD Month Day Year Hour January 31, 1968 7:40 P.M.	
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 10-4-1893		10. AGE (In years last birthday) 74	
11. BIRTHPLACE (State or foreign country) BALTO. MD		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 213-20-2585	
18. INFORMANT Sophia Torsting		ADDRESS 323 N. MARLYN AVE #21	
19. CAUSE OF DEATH E 953 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Asphyxia due to hanging (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22D. TIME OF INJURY (APPROX.) between 1-30 9:30 P & 1-31 7:00 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Hanged self		21. AUTOPSY? (Yes or No) Yes	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED February 1, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-2-68	
24C. NAME OF CEMETERY or CREMATORY Oaklawn Cemetery		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD	
25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		25B. NAME OF REGISTRAR Robert E. Tabor	
25C. FUNERAL DIRECTOR Elkum Rth Armacost		ADDRESS 466 Liberty Apts Ave	

Notes, June 1, 1962

Notes, June 1, 1962

Notes, June 1, 1962

Notes, June 1, 1962

Notes, June 1, 1962

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1372
68-1372				CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH
		LEON WELDON STOUT		FEBRUARY 3, 1968 4 50 A.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
		A. STATE MARYLAND B. COUNTY 53-00		
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		C. CITY OR TOWN BALTIMORE, MD.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
H4		E. STREET AND NUMBER 60 BUKSHIRE RD.		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-25-99	9. AGE (In years last birthday) 68
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ADVERTISING		10B. KIND OF BUSINESS OR INDUSTRY BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOSEPH G STOUT		14. MOTHER'S MAIDEN NAME CLAUDIA KINGLING		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-05-2846		17. INFORMANT MRS. MARY T. STOUT
				ADDRESS SAME
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.9 + 1188X		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ACUTE MYOCARDIAL INFARCTION		6 days
		(B) ARTERIOSECTOTIC HEART DISEASE YEARS DUE TO, OR AS A CONSEQUENCE OF:		
		(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II		CAUSE OF DEATH CARCINOMA of BLADDER		14 months
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from JAN 23 1968 to FEB 3 1968, that (I) (we) last saw the deceased alive on FEB 3 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE James W. Carty, Jr. M.D.		23B. DATE SIGNED 2/3/68		
23C. PHYSICIAN'S NAME (Type) JAMES W. CARTY, JR.		23D. ADDRESS THE UNION MEMORIAL HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/6/68		24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Cemetery
24D. LOCATION Cockeysville, Md.				
25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		25B. NAME OF REGISTRAR Charles E. Taylor		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. 21204

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1373

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-1373

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Charles Franklin Ensor

2. DATE AND HOUR OF DEATH

2-2-1968

9:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

90 Harford Gardens Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

Baltimore Co.

53-00

C. CITY OR TOWN

Sparks

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

None

5. SEX

Male

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

Sept. 29, 1873

9. AGE (In years
last birthday)

94

If Under 1 Yr.
Months Days

If Under 24 Hrs.
Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Lumber

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Sparks, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George K. Ensor

14. MOTHER'S MAIDEN NAME

Sally Cole

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

214-34-3452

17. INFORMANT

C. Roland Ensor 5309 Herring Run Dr. 21214

ADDRESS

18. 440.9 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

Generalized Arteriosclerosis

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

2 years

MEDICAL CERTIFICATION

45-0.0 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 19 66 to Feb 2 19 68,
that (I) (we) lost saw the deceased alive on Feb 2 19 68 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Loy M. Zimmerman M.D.

Attending
Phys. ☒

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

2/5/68

23C. PHYSICIAN'S
NAME (Type)

Loy M. Zimmerman M.D.

23D. ADDRESS

3202 Harford Rd. Baltimore, Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

2/6/68

24C. NAME OF CEMETERY or CREMATORY

Bosley Cemetery

24D. LOCATION

(City, town, or county)

Baltimore Co. Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

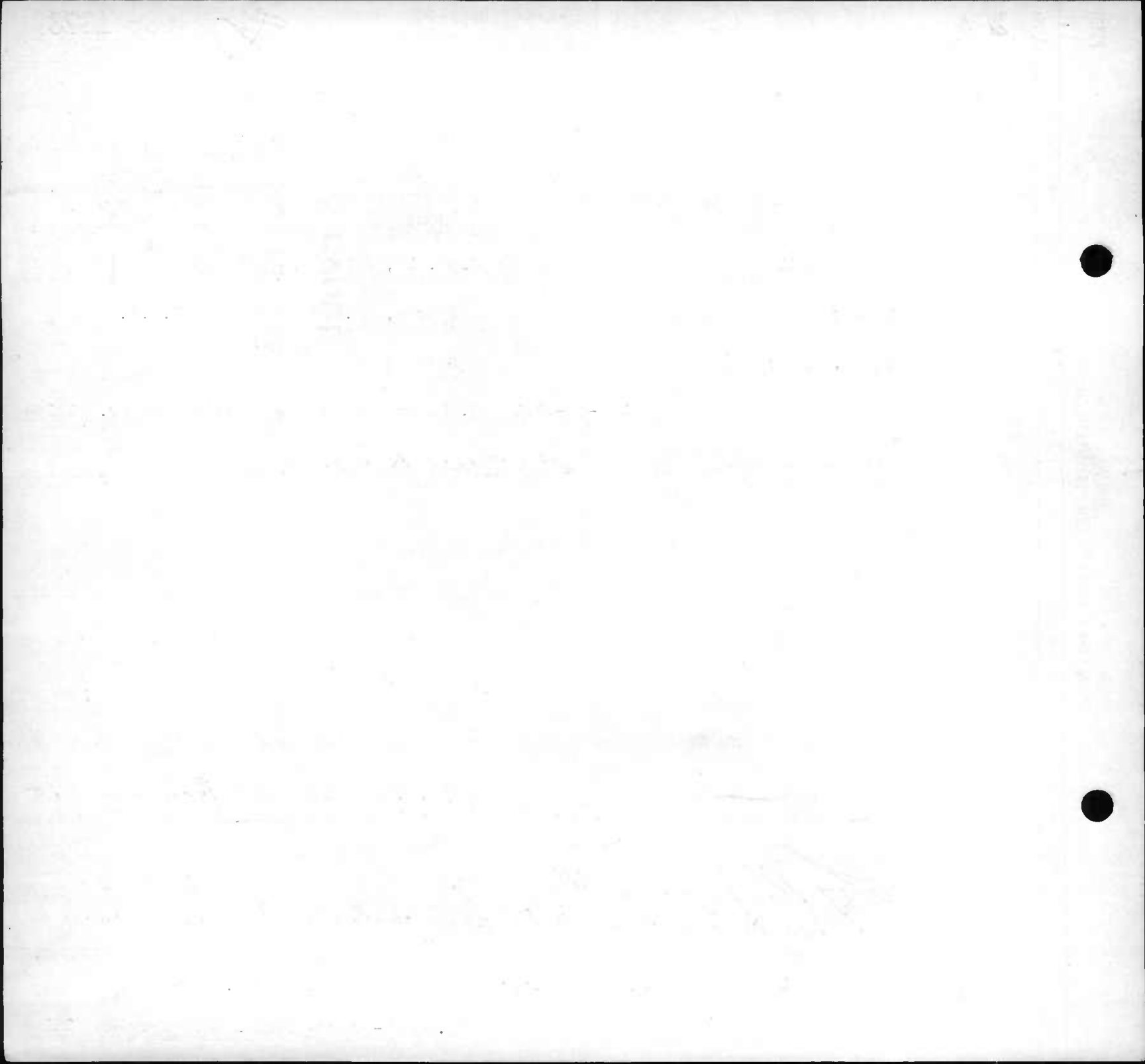
25C. FUNERAL DIRECTOR

ADDRESS

FEB 5 1968

Robert E. Fisher

Wm. Cook-Brooks Towson 1050 York Rd 21204



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-1374</u>	
<div style="display: flex; justify-content: space-between;"> 5-5136 68-1374 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) Della (Maxey) Smith			2. DATE AND HOUR OF DEATH January 30, 1968 2:25 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 16 W. 24th St. Baltimore, Md. 21218			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 12-06 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 16 W. 24th St.		
5. SEX Female	6. RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1884	9. AGE (In years last birthday) 83	10. Under 1 Yr. Months: 2 Days: 10 Hours: 10
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Harlan, Ky.
13. FATHER'S NAME John Maxey			14. MOTHER'S MAIDEN NAME Mary Johnson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. ?		17. INFORMANT ADDRESS Mr. Robt. Garland 16 W. 24th St. Balto. Md.
18. 436.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) cerebro-vascular accident ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. arteriosclerosis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 33 IX II			18 months		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-20-63 to Jan 30 19 68 , that (I) (we) last saw the deceased alive on Jan 29 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>H</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. Ellsworth Cook				23B. DATE SIGNED 1-30-68	
23C. PHYSICIAN'S NAME (Type) E. ELLSWORTH COOK M.D.				23D. ADDRESS 2431 Maryland Ave. Balto Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/1/68		24C. NAME OF CEMETERY OR CREMATORY Seal Cemetery	
24D. LOCATION Montgomery Co., Md.		25A. DATE REC'D BY HEALTH DEPT. FEB 6 1968			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks, Inc. 1217 St. Paul St.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1375

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 935

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Oles, CARRIE

2. DATE AND HOUR OF DEATH

1/31/68

12 50 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

Bolton Hill Nursing Center
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

FULL NAME OF HOSPITAL OR INSTITUTION

90

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

3025 WINDSOR AVE

5. SEX

F

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

7-14-86

9. AGE (In years last birthday)

81

10. Under 1 Yr. Months: Days: Hours: Min.

10 10 10 10

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

BALTIMORE, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles CLAS.

14. MOTHER'S MAIDEN NAME

Augusta Walker

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

212-56-9659

17. INFORMANT

Admission Record

ADDRESS

18.

412.9 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

cerebro-vascular accident

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

A.S.C.V.D.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 day

Several yrs

MEDICAL CERTIFICATION

422.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

Osteo arthritis-
Chronic rectal abscess

Several yrs.

2 yrs.

19A. DATE OF OPERATION

7

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-3-1966 to 1-31-1968, that (I) (we) last saw the deceased alive on 1-25-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

E. Ellsworth Cook MD

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

1-31-68

23C. PHYSICIAN'S NAME (Type)

E. Ellsworth Cook MD

23D. ADDRESS

2431 Maryland Ave. Balto. Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

Cremation

24B. DATE

2/3/68

24C. NAME of CEMETERY or CREMATORY

Greenmount Cem.

24D. LOCATION

Balto., Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

FEB 5 1968

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

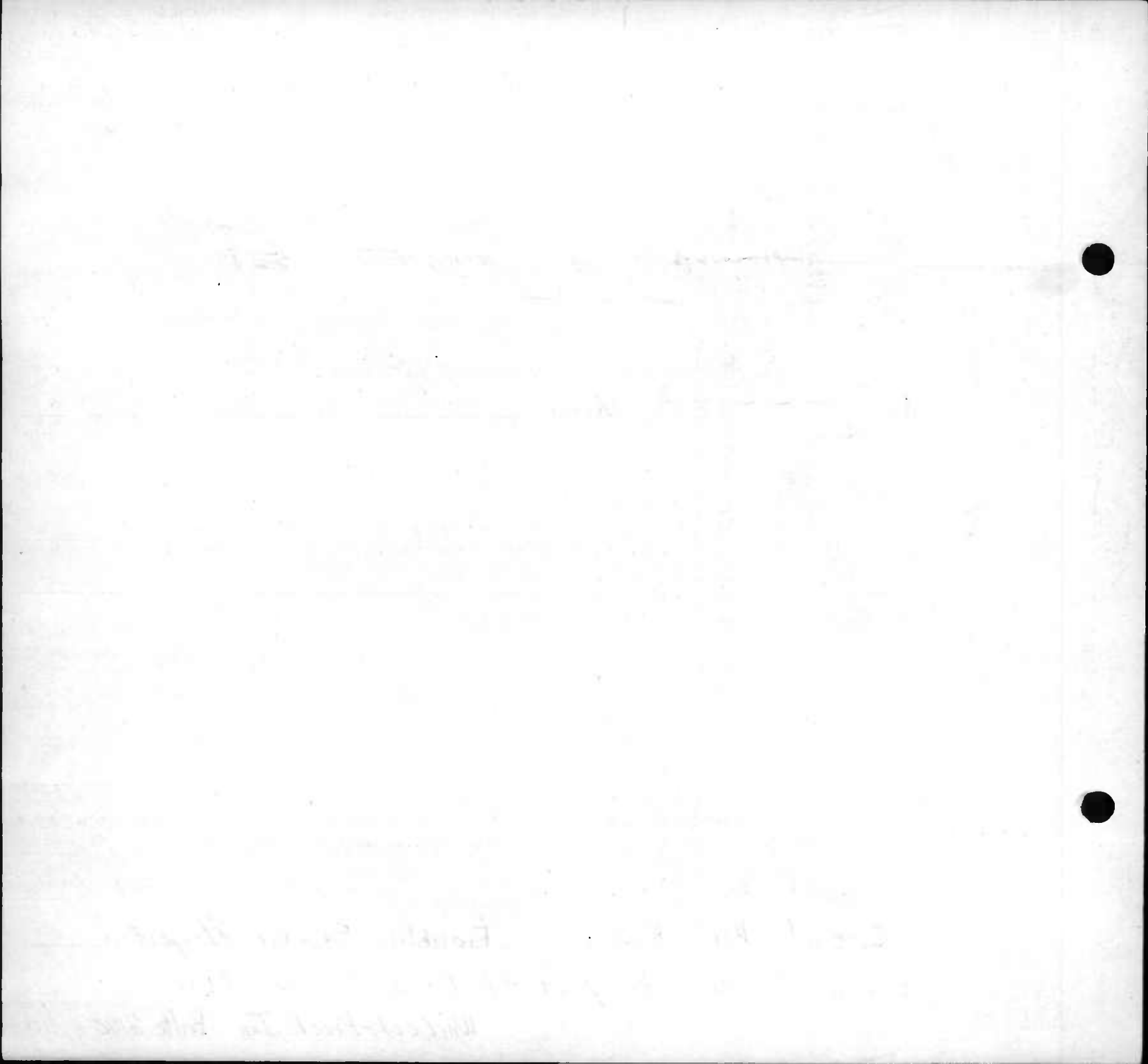
Wm Cook-Brooks, Inc. 1217 St. Paul St. Balto.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-1376</u>
BIRTH NO. <u>68-1376</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>GOROG, EUGEN</u>		2. DATE AND HOUR OF DEATH <u>1st. Feb. 1968</u> <u>3, 30 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>FRANKLIN SQUARE HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>M. D.</u> B. COUNTY <u>27-17</u>		
		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
		E. STREET AND NUMBER <u>3023 OAKLEY AVE.</u>		
5. SEX <u>M</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-17-1919</u>	9. AGE (In years last birthday) <u>48</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY — — — — —		11. BIRTHPLACE (State or foreign country) <u>HUNGARY</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>		13. FATHER'S NAME <u>JOHN GOROG</u>		
14. MOTHER'S MAIDEN NAME <u>KNEBL, ROSOLIA</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>ANNA SZORRI</u>		
18. ADDRESS <u>3023 OAKLEY AVE.</u>		19. CAUSE OF DEATH <u>C. V. A</u>		
20. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>331X II</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>331X II</u>				
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>331X II</u>				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>24th JAN.</u> 19 <u>68</u> to <u>1st. Feb.</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3:30 AM 1st. Feb.</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Cheul Du, Kwon</u>				23B. DATE SIGNED <u>1st. Feb. '68</u>
23C. PHYSICIAN'S NAME (Type) <u>Cheul Du Kwon</u>		23D. ADDRESS <u>Franklin Square Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>2-5-1968</u>	24C. NAME OF CEMETERY or CREMATORY <u>Prospect Hill Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Towson, Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 5 1968</u>		25B. NAME OF REGISTRAR <u>R. E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Wm Cook-Brooks, Inc.</u>
				ADDRESS <u>Balto, 21202, Md</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1377

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 1377

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

KOKOSZKI, Stanley

2. DATE AND HOUR OF DEATH

2-2-68 1:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Church Home and Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

2101 E Lombard St.

5. SEX

MALE

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

4-23-23

9. AGE (In years last birthday)

44

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

TAVERN Owner

10B. KIND OF BUSINESS OR INDUSTRY

BAR

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Michael Kokoszki

14. MOTHER'S MAIDEN NAME

Rose Wenzask

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

ANN KOKOSZKI 2101 E. LOMBARD ST

ADDRESS

18.

412.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

PULMONARY INFARCTION

(B)

DUE TO, OR AS A CONSEQUENCE OF:

EMPHYSEMA

(C)

ARTERIO-SCLEROTIC HEART DISEASE

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DAYS

YEARS

MEDICAL CERTIFICATION

420.0 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb 1 19 68 to Feb 2 19 1968, that (I) (we) last saw the deceased alive on Feb 2 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

[Signature]

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

Feb 2, 1968

23C. PHYSICIAN'S NAME (Type)

VENERABLE

23D. ADDRESS

CHURCH HOME AND HOSP.

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

2-6-68

24C. NAME of CEMETERY or CREMATORY

HOLY ROSARY CEM.

24D. LOCATION

BALTO

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

FEB 5 1968

25B. NAME OF REGISTRAR

[Signature]

25C. FUNERAL DIRECTOR

JOHN M WEBER & SONS INC 4015 CHESTER ST

ADDRESS

Maryland
Rose Beach

to the
at the

VERMONT
to the
CHURCH

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-1378

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CLEMENT W. STICKLINE

2. DATE AND HOUR OF DEATH

Feb. 1, 1968

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00
4 N. Ellwood Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

4 N. Ellwood Ave.

5. SEX

Male

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Oct. 3, 1914

9. AGE (In years last birthday)

53

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

BOOKMAKER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John Stickline

14. MOTHER'S MAIDEN NAME

MARY E. LIND

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

213-05-5221

17. INFORMANT

Elizabeth Stickline 4 N. Ellwood Ave

ADDRESS

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

CARCINOMA OF LUNG

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

10 months

MEDICAL CERTIFICATION

163X II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from MAY 11 1967 to DEC. 28 1967, that (I) (we) last saw the deceased alive on DEC. 28 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Raymond E. Lenhard Jr.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

Feb. 5, 1968

23C. PHYSICIAN'S NAME (Type)

Raymond E. Lenhard, Jr., M.D.

23D. ADDRESS

Johns Hopkins Hospital, Baltimore, Md. 21205

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

2/5/68

24C. NAME OF CEMETERY OR CREMATORY

OAKLAWN CEMETERY

24D. LOCATION

Baltimore Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

FEB 5 1968

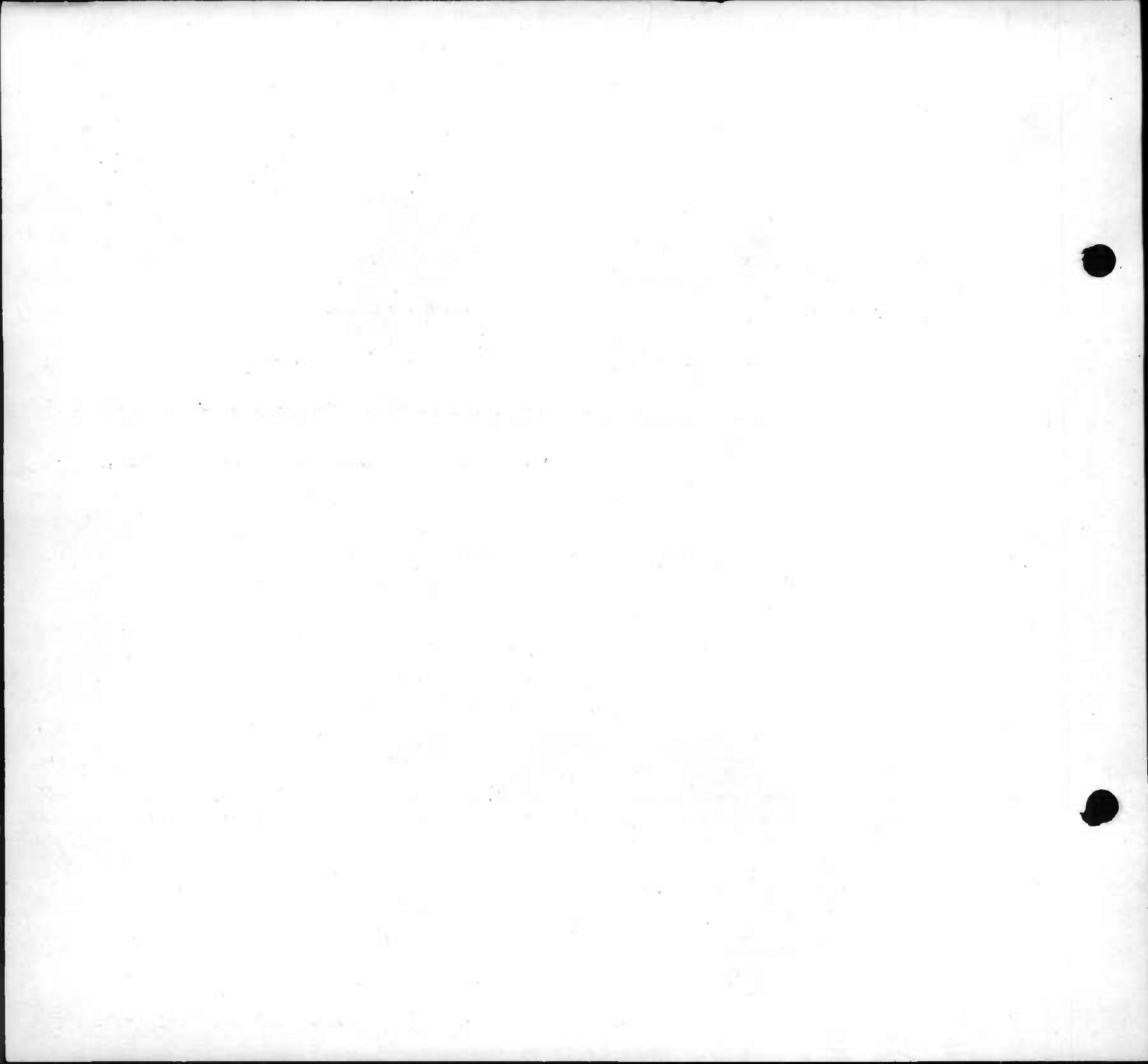
25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

B. DABROWSKI 2118 E. BALTO. ST.

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
68-1379		CERTIFICATE OF DEATH		68-1379	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		MR. JESSIE A. SCHOOLING		Feb 4, 1968 12:40 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Church Home & Hospital		Md. 6-03			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
M		W		WIDOWED	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Merchant Seaman				Missouri	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Emmanuel Schooling		Maggie Stollwaggon		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		559-05546		Elsie V. Schooling 2205 E Fayette St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		Myocardial infarction			
ANTECEDENT CAUSES		Thrombotic infarction			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Generalized arteriosclerosis			
420.1 II		Angina pectoris. Hypertension			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0 -					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		White A1 <input type="checkbox"/> Not White A1 <input type="checkbox"/>			
-					
22. I certify that (I) (this hospital) attended the deceased from Feb 3 1968 to Feb 4 1968, that (I) (we) last saw the deceased alive on Feb 4 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
B. Albina					
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
BERNARD ALBINA		CHURCH HOME & HOSPITAL Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		2-7-1968		Union	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
FEB 5 1968		Robert E. Taylor		X. Howard Strong 307 W North Ave	

2-17-77

Specialist in outdoor education
Angus F. Fickel, Ph.D.

B. C. (Gunn)
BERNARD ALBINA

CHURCH HOME & HOSPITAL - BOSTON

X. F. Fickel, Ph.D.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1380

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 1380

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Louise Elizabeth Thomas

2. DATE AND HOUR OF DEATH

Feb. 1, 1968

10 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

US Public Health Service Hospital
3100 Wyman Pk. Drive

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

Edgewater

D. INSIDE CITY LIMITS?

YES ☐

NO ☐

E. STREET AND NUMBER

113 Dorsey Drive

5. SEX

F

6. RACE

Col

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

7 / 12 / 10

9. AGE (In years last birthday)

57

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Edward Smith

14. MOTHER'S MAIDEN NAME

Jessie Smith

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

212-26-4477

17. INFORMANT

ADDRESS

Records- US PHS Hospital, Balto, Md.

18.

196.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

Metastatic cervical

DUE TO, OR AS A CONSEQUENCE OF

cervix inoma

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

4 yrs. ?

MEDICAL CERTIFICATION

198.0 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Oct. 24 19 67 to Feb. 1 19 68, that (I) (we) last saw the deceased alive on Feb. 1 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Alan R. Butler MD

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

2/2/68

23C. PHYSICIAN'S NAME (Type)

Alan R. Butler, Surgeon (R)

23D. ADDRESS

US PHS Hospital, Balto, Md. 21211

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial 2-6-68 Pine Lawn Memorial Park, Annapolis Md.

25A. DATE REC'D BY HEALTH DEPT.

FEB 5 1968

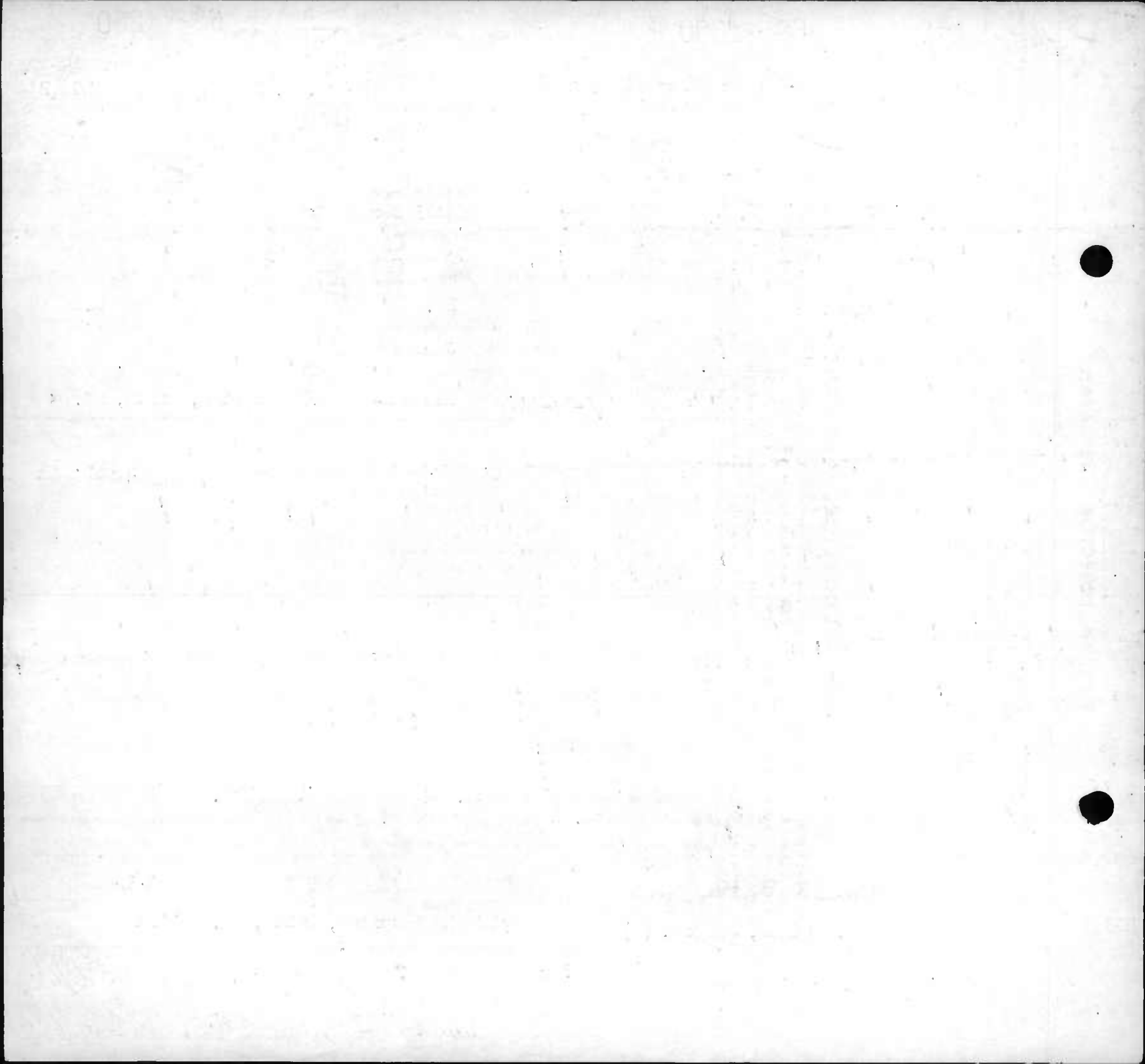
25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

William Reese, Jr. Annapolis Md.

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1381
CERTIFICATE OF DEATH				
BIRTH NO. 68-1381				
1. NAME OF DECEASED (Type or Print) <i>OLIVER H CRISP</i>		2. DATE AND HOUR OF DEATH <i>2/3/68 6:30 P.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>14-01</i>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>1822 Buxton Street</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <i>1822 Buxton Street</i>				
5. SEX <i>male</i>	6. RACE <i>col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12 12 16 51</i>	9. AGE (In years last birthday) <i>51</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labor</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Melbourne NC</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
13. FATHER'S NAME <i>Buddie Crisp</i>		14. MOTHER'S MAIDEN NAME <i>Louise Thompson</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>2 41 1238</i>		17. INFORMANT <i>Grace Short Baker Street</i>
18. <i>410.9 I</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CORONARY THROMBOSIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>420.1 II</i>				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <i>1/16/68</i> 19 to <i>1/31/68</i> 19 that (I) (we) last saw the deceased alive on <i>1/31/68</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>[Signature]</i>		23B. DATE SIGNED <i>2/5/68</i>		
23C. PHYSICIAN'S NAME (Type) <i>HONNIE JENNARINE</i>		23D. ADDRESS <i>930 WHITELOCK ST. BALT. Md</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial Feb 10, 1968</i>		24B. DATE		24C. NAME OF CEMETERY or CREMATORY <i>Mt Auburn</i>
24D. LOCATION (City, town, or county) (State) <i>Mt Auburn</i>				
25A. DATE REC'D BY HEALTH DEPT. <i>FEB 5 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Althea L McQuinn</i>
				ADDRESS <i>2302 W North Ave</i>

only call
Rudolf's Corp

20
Mellon's
James T. Mellon

no

1/1/12

1/1/12

James T. Mellon
James T. Mellon

James T. Mellon
James T. Mellon
James T. Mellon

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 685 1382	
1. NAME OF DECEASED (Type or Print) FIELDING, LEWIS			2. DATE AND HOUR OF DEATH 2/3/68 1:00 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Bolton Hill Nursing & Convalescent Ctr.			A. STATE Maryland B. COUNTY 3-02		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 26 S. Exeter Street					
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/17/95	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
Self employed			Maryland		
13. FATHER'S NAME Frederick Lewis Sr			14. MOTHER'S MAIDEN NAME Louise Jackson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 217-01-4732		
17. INFORMANT FIELDING WALLACE 1602 PUEB ST			ADDRESS		
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) acute coronary occlusion			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. congestive heart failure			years		
420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). myocardial infarction			years		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/14 19 67 to 2/3 19 68 , that (I) (we) last saw the deceased alive on 2/3 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE all [signature]				23B. DATE SIGNED 2/3/68	
23C. PHYSICIAN'S NAME (Type) ALLAN H. NACHT MD				23D. ADDRESS 2 E READ ST BALTIMORE MD 21202	
24A. BURIAL CREMATION, REMOVAL (Specify) Burn		24B. DATE 2/1/68		24C. NAME OF CEMETERY OR CREMATORY MT AUBURN	
24D. LOCATION (City, town, or county) (State) BALTO MD					
25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		25B. NAME OF REGISTRAR Robert E. Fairley		25C. FUNERAL DIRECTOR W. J. Hager 638 N GILMAN ST	

1914

no
Tuesdays
to be observed

to be observed
Tuesdays

5-530

68-1383

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-1383

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Smith Anna L.

2. DATE AND HOUR OF DEATH

2-2-1968

11 35

P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

42

Sinai Hospital
Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Md.

B. COUNTY

C. CITY OR TOWN
Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

3308 Mondawmin Ave.

5. SEX

F

6. RACE

N

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

5-18-1915

9. AGE (In years
last birthday)

52

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James K. Smith

14. MOTHER'S MAIDEN NAME

Nezzie Wall

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

220307089

17. INFORMANT

ADDRESS

Charles Smith 4329 3rd St. Wash., D.C.

18. *E 931.21*

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Massive Hepatic Necrosis

2-3 days

(B) *Homologous Serum Jaundice*

DUE TO, OR AS A CONSEQUENCE OF:

about 10 days

(C) *interruption of leg*

DUE TO, OR AS A CONSEQUENCE OF:

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A)

19A. DATE OF OPERATION

2 NOV 1967

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

OCCLUSIVE ASCVD of iliac arteries

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
NOV - 67 -21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

HOSPITAL -

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

SINAI HOSPITAL 2-17

21F. HOW DID INJURY OCCUR?

received 17 bottles of blood at operation

AT SINAI HOSP. 35

(3 PM) 19 68 to Feb 2 (11 PM) 19 68

22. I certify that (I) (this hospital) attended the deceased from Feb 2 (3 PM) 19 68 to Feb 2 (11 PM) 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Myung Sun Yoon

DEGREE

Attending
Phys.Med.
DirectorStaff
Phys.

23B. DATE SIGNED

23C. PHYSICIAN'S
NAME (Type)

MYUNG SUN YOON

DEGREE

23D. ADDRESS

Sinai Hospital

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

2-7-68

24C. NAME OF CEMETERY or CREMATORY

Arbutus Mem. Park

24D. LOCATION

(City, town, or county)

Arbutus

Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

FEB 5 1968

25B. NAME OF REGISTRAR

G. E. Tanaka

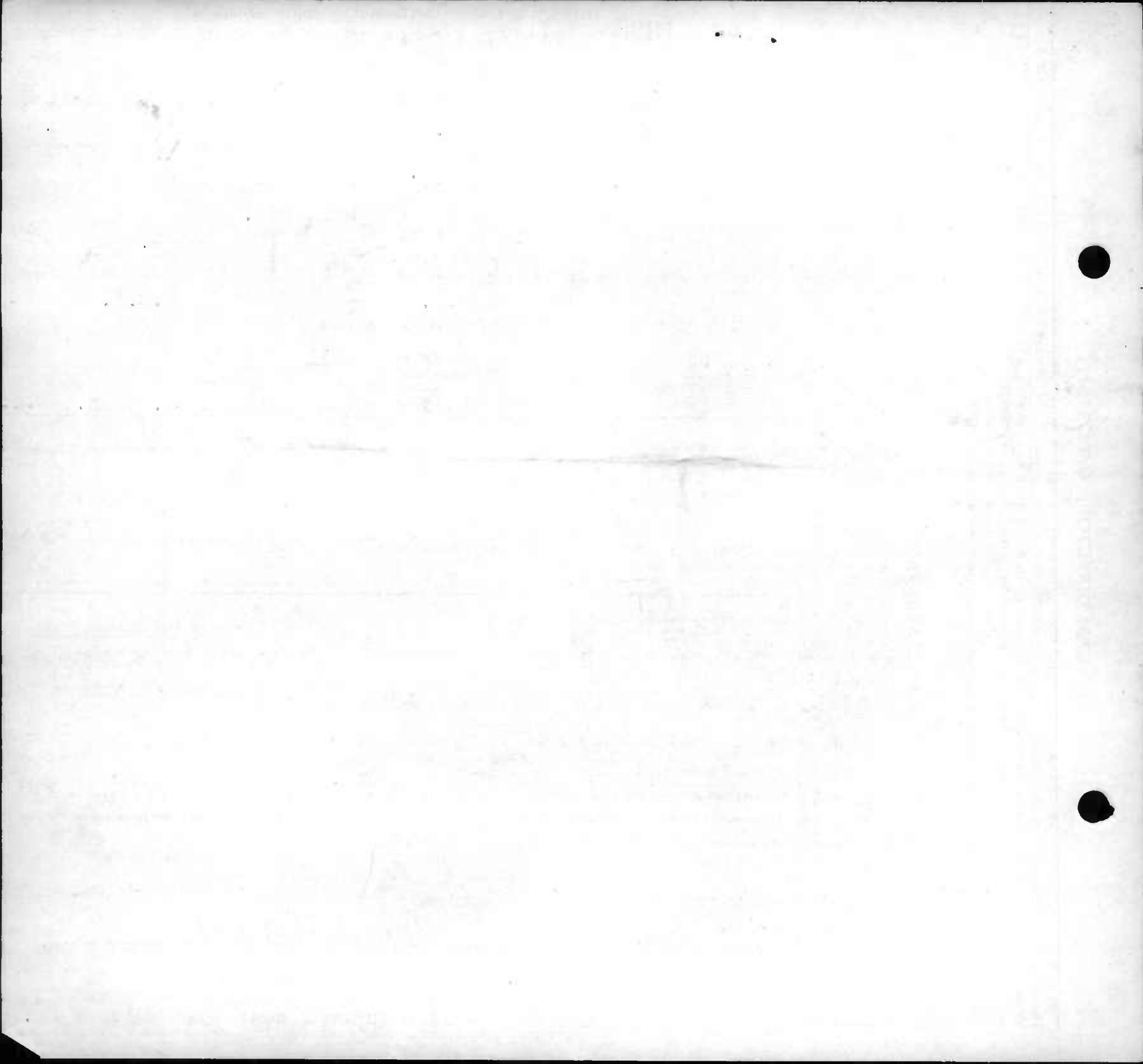
25C. FUNERAL DIRECTOR

Kelson Funeral Home 1348 Calhoun St.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

51-02-921		68-1384		BALTIMORE CITY HEALTH DEPARTMENT		68-1384	
CERTIFICATE OF DEATH				REG. NO.			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		MRS. CURLENE CARTER		FEB 2/68 830 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY	
31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND				MARYLAND			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				2438 DORTON COURT		21230	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
FEMALE		NEGRO		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8-31-07	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)	
				60		VIRGINIA	
12. CITIZEN OF WHAT COUNTRY?				USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
RICHARD VEENEY				CREALE VEENEY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
no				RECORDS-BCH-4940 EASTERN AVENUE		BALTIMORE MD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				16 mos.			
ANTECEDENT CAUSES				16 mos.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				16 mos.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				16 mos.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2		—		YES		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from JAN 26 1968 to Feb 2 1968, that (I) (we) lost saw the deceased alive on FEB 2 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
F. Y. Aoki				Feb 2/68			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
F. Y. Aoki				40 Balt City Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		2-6-68		Arbutus Mem. Pk.		Arbutus Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
FEB 5 1968		R. E. Taylor		Kelson Funeral Home 1348 Calhoun St.			

ALLIANCE FOR PROGRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1385

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-1385

BIRTH NO.		1. NAME OF DECEASED (Type or Print) M. AGNES STELLA		2. DATE AND HOUR OF DEATH 2.2.68 110 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY CITY OF BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 814 NORTH KENWOOD AVENUE		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-2-12	9. AGE (In years last birthday) 55	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME MICHAEL SEABURGER			14. MOTHER'S MAIDEN NAME MARY LEONARD		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Pasquale Stella 814 N. Kenwood Ave. Balto		
18. 734.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Prob. Con. neg sepsis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Urinary Tract infection			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 3 days
19. 45-6X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Systemic lupus erythematosus			20. 5 years		
19A. DATE OF OPERATION 1.14.68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Myopneumothorax	20A. AUTOPSY? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 2.2.68 to 2.2 19 68 , that (I) (we) last saw the deceased alive on 2.2 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Christopher B. Merritt MD			23B. DATE SIGNED 2.2.68		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) Christopher B. Merritt, MD.			23D. ADDRESS Johns Hopkins Hospital, Balto., Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE Feb. 6, 68	24C. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer Cem.	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR ADDRESS Dippel Brothers Inc 1800 E. Lombard St.		

1892

1893

1894

1895

1896

1897

1898

1899

1900

1901

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1386

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-1386

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

BURNELL

STEVENSON

2. DATE AND HOUR OF DEATH

2/2/68

9:25 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 3903 Mountwood Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☐NO ☐

E. STREET AND NUMBER

3903 Mountwood Road

5. SEX

M.

6. RACE

N.

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

5-15-1915

9. AGE (In years
last birthday)

52

If Under 1 Yr.
Months: DaysIf Under 24 Hrs.
Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

STEVEDORE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

WINNSBORO, S.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Stevenson

14. MOTHER'S MAIDEN NAME

Cora Evans

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

217-07-1241

17. INFORMANT

ADDRESS

Mrs. Mamie Stevenson 3903 Mountwood

18.

150X I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Carcinoma of Esophagus
C Metastasis

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

8 months

MEDICAL CERTIFICATION

150X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 16 1967 to July 2 1968,
that (I) (we) last saw the deceased alive on July 1 1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Roland T. Smoot, M.D.

OEGREE

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

2/2/68

23C. PHYSICIAN'S
NAME (Type)

ROLAND T. SMOOT, M.D.

OEGREE

23D. ADDRESS

3817 CUPLEY RD. BALTO. 15, MD

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

2-6-68

24C. NAME OF CEMETERY or CREMATORY

Arbutus Memorial Park

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

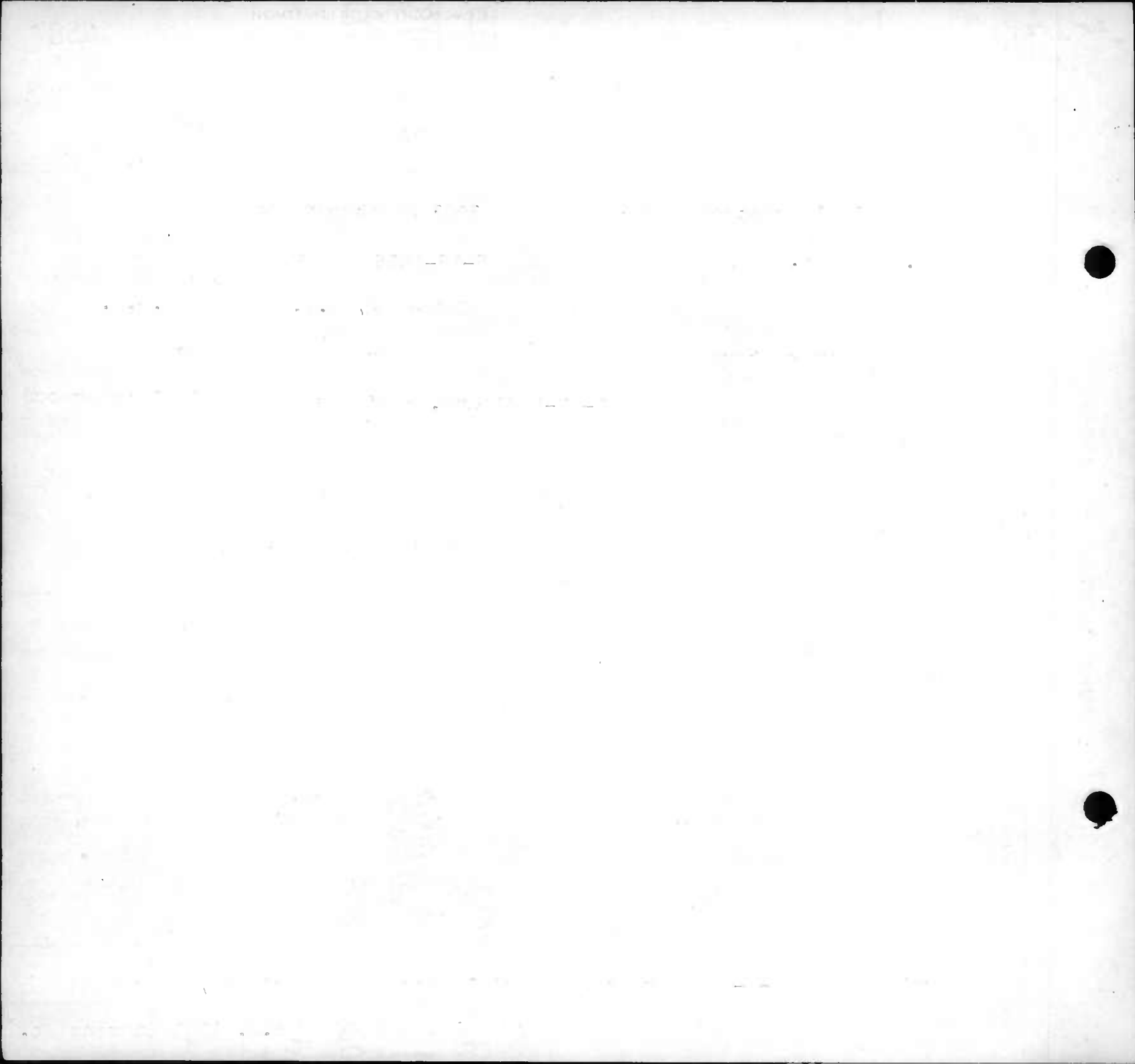
25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

MORTON & DYETT F.H. 1701 Laurens St.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 1387 CERTIFICATE OF DEATH

REG. NO. 68- 1387

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

KATHERINE HAMILTON TOLLIVER

2. DATE AND HOUR OF DEATH

1-31-68

12:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 3410 Woodbrook Avenue

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

F. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

3410 Woodbrook Avenue

5. SEX

F.

6. RACE

Negro

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

6-20-1929

9. AGE (In years
last birthday)

38

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

DOMESTIC WORK

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

SALISBURY, NORTH CAROLINA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

GRANT HOWARD

14. MOTHER'S MAIDEN NAME

ADA RANDLE

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Andrea Randle 2024 Linden Ave

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

Adenocarcinoma
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(Cervix)APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

Scv. mos.

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

10/67

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

Carcinoma

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7/24 1967 to 1/31 1968.
that (I) (we) last saw the deceased alive on 1/22 1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S
NAME (Type)

RAYNER BROWNE, M.D.
1500 EAST MADISON ST.
BALTIMORE, MD. 21204

23D. ADDRESS

Med. Director ☐Staff Phys. ☐

23B. DATE SIGNED

2-2-68

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

2-5-68

24C. NAME OF CEMETERY or CREMATORY

Mount Auburn Cemetery

24D. LOCATION

Baltimore,

(City, town, or county)

(State)

Maryland

25A. DATE REC'D BY HEALTH DEPT.

FEB 5 1968

25B. NAME OF REGISTRAR

R. B. E. E. E.

25C. FUNERAL DIRECTOR

MORTON & DYETT F.H. 1701 Laurens St.

ADDRESS

Atenciones
(Cervix)

NO

10/07

10/07

1/01

1/05/01

NOTES
TO
10/07

D-130
D-120

68-1388

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-1388

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) IDEIA (Idelia David) DAVIS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> February 3, 1968 2:45 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1351 N. Stricker Street (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour February 3, 1968 2:45 A.M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 15-01	
9. DATE OF BIRTH 4-15-1930		10. AGE (In years lost birthday) 37 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME McKinley Smith		14. STREET AND NUMBER 1351 N. Stricker Street	
15. MOTHER'S MAIDEN NAME Unk.		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.	
17. SOCIAL SECURITY NO. 214-26-1384		18. INFORMANT ADDRESS Mr. John David 1326 Woodyear Street	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Intracerebral Hemorrhage ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Hypertensive Cardiovascular Disease OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Pyelonephritis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2-3-68	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-7-68	
24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		25B. NAME OF REGISTRAR R. E. Taylor	
25C. FUNERAL DIRECTOR MORTON & DYETT F.H.		ADDRESS 1701 Laurens St.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1389

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-1389

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Martha T. Monroe</i>		2. DATE AND HOUR OF DEATH <i>Feb. 2, 1968</i> <i>1:45 P</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>42 Sinai Hospital</i>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD</i> B. COUNTY C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>2914 Hilldale Ave</i>		
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/3/04</i>	9. AGE (in years last birthday) <i>63</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Domestic Work</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	
13. FATHER'S NAME <i>John Spriggs</i>			14. MOTHER'S MAIDEN NAME <i>Hattie Spriggs</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Shirley Diggs</i> ADDRESS <i>2914 Hilldale St</i>	
18. <i>436.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebrovascular Accident</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 hrs</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>331X II</i>					
19A. DATE OF OPERATION <i>D</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Feb. 2</i> 19 <i>68</i> to <i>death</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Feb. 2</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Robert J. Dan, M.D.</i> DEGREE				23B. DATE SIGNED <i>Feb 2, 1968</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <i>3009 Doran Ct, Baltimore Md</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>2-7-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Mem. Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>FEB 5 1968</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor, MA</i>		25C. FUNERAL DIRECTOR <i>Morton & Dyett F.H.</i>		25D. ADDRESS <i>1701 Laurens</i>	

John Spradley
Domestic water Baltimore Maryland

He started 1st 2nd 3rd 4th

Morton & Dyett
Baltimore

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1390

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68-1390

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Roger Arvin</i>		2. DATE AND HOUR OF DEATH <i>1/30/68 11:30 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Union Memorial Hosp.</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>12-04</i>	
5. SEX <i>M</i>		6. RACE <i>N</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>9/13/1900 68</i>	
13. FATHER'S NAME <i>William Arvin</i>		14. MOTHER'S MAIDEN NAME <i>Bertamae P</i>		9. AGE (In years last birthday) <i>68</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Hospital Record</i>	
18. <i>690.21</i>		CAUSE OF DEATH <i>Septic Shock</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>renal abscess</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Acute leukitis</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>600.1 II</i>		(C) <i>Septicemia</i>			
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <i>12/10/67</i> to <i>1/30/68</i> , that (I) (we) last saw the deceased alive on <i>1/30/68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Dr. Harry F. Holcomb, Jr.</i>				23B. DATE SIGNED <i>1/30/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>DR. HARRY F. HOLCOMB, JR.</i>				23D. ADDRESS <i>THE UNION MEMORIAL HOSPITAL Union Memorial Hosp.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>2-3-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt Auburn Cem</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Rayner Sanders</i>		25C. FUNERAL DIRECTOR <i>217 E. Preston St</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto. Md</i>					

2200 08
2200 08

W. H. H.
W. H. H.

2200 08

2200 08

2200 08

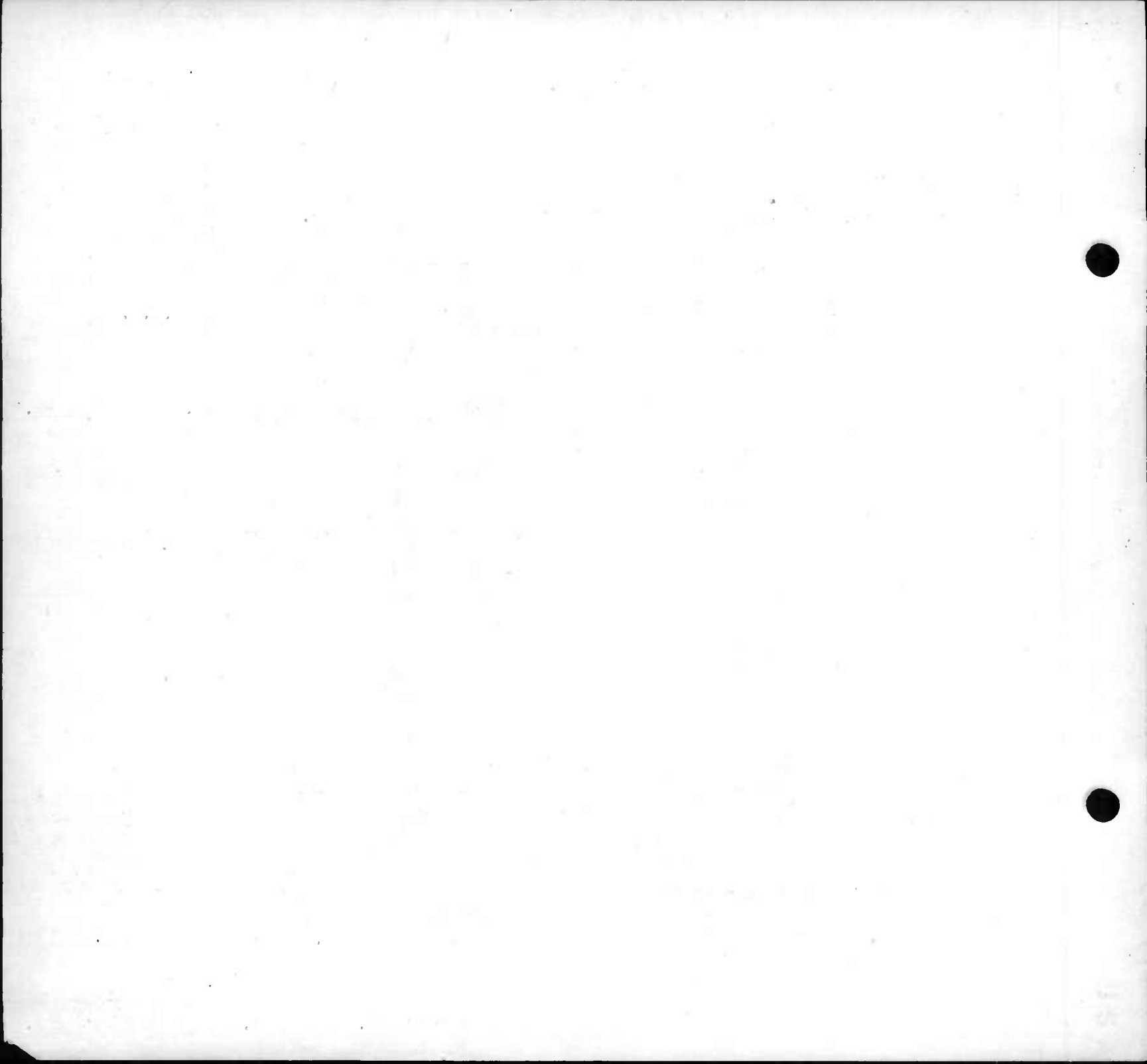
2200 08

W. H. H.
W. H. H.

W. H. H.
W. H. H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-400		68-1391		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1391	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) PAUL ANNIE A.			
2. DATE AND HOUR OF DEATH 2-4-68 3:50 P.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland # 21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4940 Eastern Ave. # 21224			
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-13-74	
9. AGE (In years last birthday) 93		10. UNDER 1 Yr. Months: Days: Hours: Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY Home			
13. FATHER'S NAME ? Thomas				14. MOTHER'S MAIDEN NAME Amelia ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 216013739		17. INFORMANT ADDRESS #21224 BCH: Records 4940 Eastern Ave. Baltimore, Md.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 443X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 6-8-68 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 8 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> At Work 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 2-19-68 to 2-4-68, that (I) (we) last saw the deceased alive on 2-4-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE P. Desmond 23B. DATE SIGNED 2-4-68 23C. PHYSICIAN'S NAME (Type) P. Desmond 23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland #21224 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 2/8/68 24C. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery 24D. LOCATION Baltimore, Maryland 25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd.							



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1392

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 1392

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Charles H Zerhusen

2. DATE AND HOUR OF DEATH

Feb. 4, 1968

1:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

5636 Govane Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

5636 Govane Ave

5. SEX

Male

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

May 2, 1928

9. AGE (In years
last birthday)

39

If Under 1 Yr.
Months: Days:

If Under 24 Hrs.
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Office Manager

10B. KIND OF BUSINESS OR INDUSTRY

Southern States
Sunk Cooperative

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Peter A Zerhusen

14. MOTHER'S MAIDEN NAME

Barbarba Ruck

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWII

16. SOCIAL
SECURITY NO.

213-28-3345

17. INFORMANT

Mrs Theresa Zerhusen

ADDRESS

Same

18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

BRONCHIOGENIC CARCINOMA
RIGHT LUNG

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

24 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

APRIL 1966

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

DIAGNOSTIC BIOPSY

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐

Not White
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1955 to FEBRUARY 4 1968.
that (I) (we) last saw the deceased alive on JANUARY 5 1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Melvin F. Polek, M.D.

Attending
Phys. ☒

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

2/5/68

23C. PHYSICIAN'S
NAME (Type)

Melvin F Polek M D

23D. ADDRESS

3603 Belair Rd Baltimore Md

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

2/7/68

24C. NAME OF CEMETERY or CREMATORY

Holy Redeemer

24D. LOCATION

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

FEB 5 1968

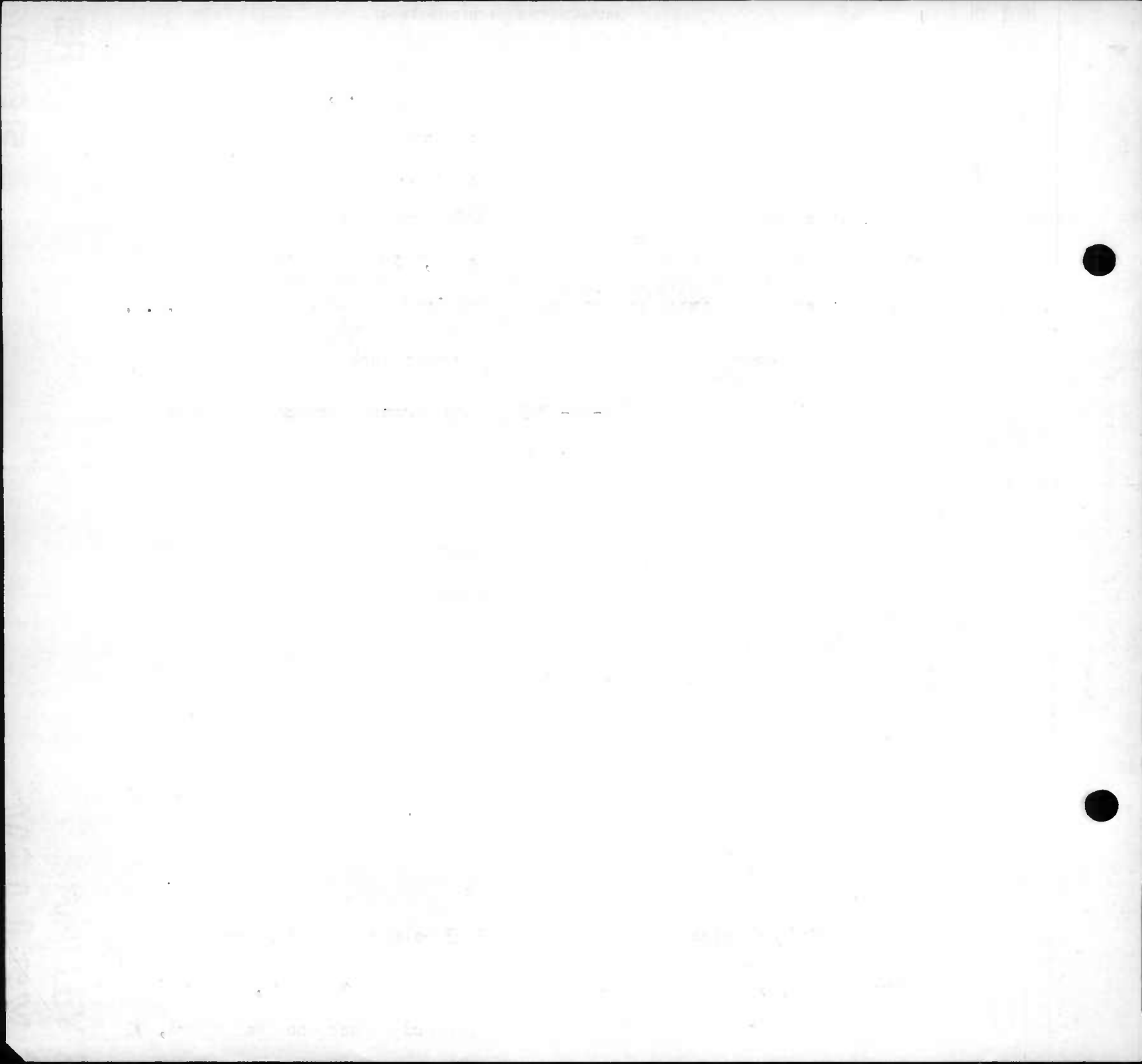
25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Leonard J Ruck Inc Baltimore, Md

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1393

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68- 1393

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

KIRKHAM, ELLA BARBARA

2. DATE AND HOUR OF DEATH

4th Feb '68 6:10 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

36 FRANKLIN SQUARE HOSPITAL.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

M.D

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☐

NO ☐

E. STREET AND NUMBER

2823 E. NORTHERN PARKWAY

5. SEX

F

6. RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

7/12/86

9. AGE (In years last birthday)

81

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U. S. A

13. FATHER'S NAME

JOHN W. HARDECKER

14. MOTHER'S MAIDEN NAME

MARY BAURENSCHMIDT

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

212056141B

17. INFORMANT MRS. ALBERT BERBERICH

4412 ELSRODE AVE. 21214

18.

436.91

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

C. U. I.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

24 hrs.

331X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

ASCUD WITH CHF & AF

Several years

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 20th JAN 19 68 to 4th Feb 19 68, that (I) (we) last saw the deceased alive on 6:10 PM 4th Feb 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Cheul Du, M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

2/4/1968

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

Franklin Sq. Hosp, Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

2/7/68

24C. NAME OF CEMETERY or CREMATORY

Parkwood Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore Co., Maryland

25A. DATE REC'D BY HEALTH DEPT.

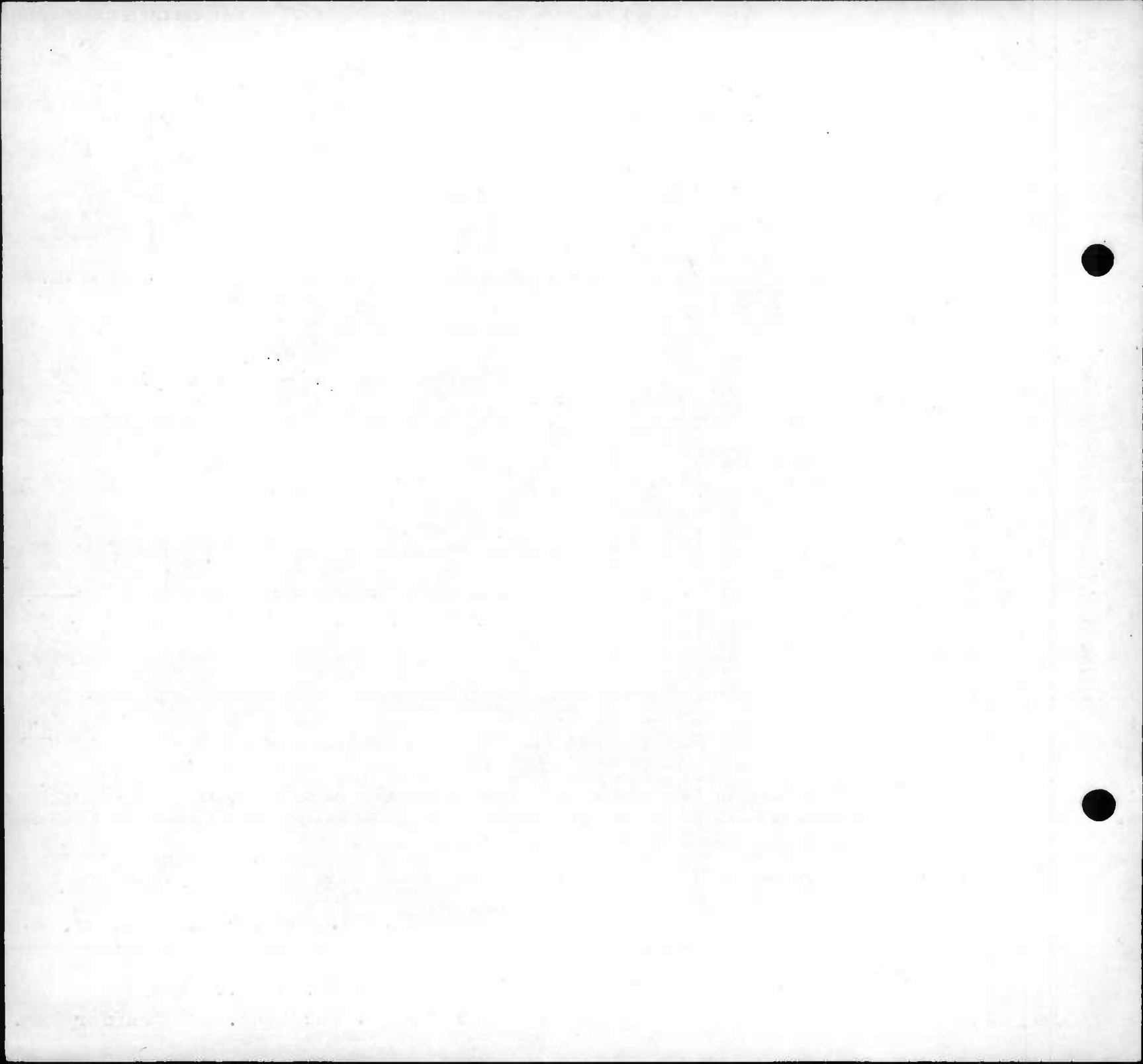
FEB 5 1968

25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

Leonard J. Ruck Inc. 5305 Harford Rd.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1394

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 1394

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Katharine M. Fay

2. DATE AND HOUR OF DEATH

February 2, 1968 7:25 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Jenkins Memorial Hospital
1000 Catton Ave.
Baltimore, Md. 21229

4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)
A. STATE B. COUNTY
Md. BALTIMORE,

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

5105 Hillburn Ave. 27-01

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

Aug. 1, 1899

9. AGE (In years
last birthday)

68 68

If Under 1 Yr.

Months: Days: Hours: Min.

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Timothy Kelly

14. MOTHER'S MAIDEN NAME

Sophia Kaufman

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

215-485-239

17. INFORMANT

ADDRESS

Jenkins Mem. Hosp. 1000 Catton Ave.

18. I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

ac myocardial infarction minutes

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Ca of the heart.

(B) DUE TO, OR AS A CONSEQUENCE OF:

Intestines see to B)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

3 years

MEDICAL CERTIFICATION

170X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐
Work

Not While ☐
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec 19 67 to Feb 19 68.
that (I) (we) last saw the deceased alive on 27 Jan 19 67 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Manuel de J Rodriguez, M.D.

DEGREE

Attending
Phys. ☒

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

2-2-68

23C. PHYSICIAN'S
NAME (Type)

23D. ADDRESS

Jenkins Memorial Hospital

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

2/5/68

24C. NAME OF CEMETERY OR CREMATORY

Baltimore National Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

FEB 5 1968

25B. NAME OF REGISTRAR

Leonard J. Ruck, Inc.

25C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc. Ba lto. Md. 21214

ADDRESS

Ba lto. Md.

Co. of the 1st
Regiment of the
Massachusetts Infantry

Wm. H. [unclear]
+ [unclear]
of [unclear] Co. 1st Regt.

FUNERAL DIRECTOR: IMPORTANT

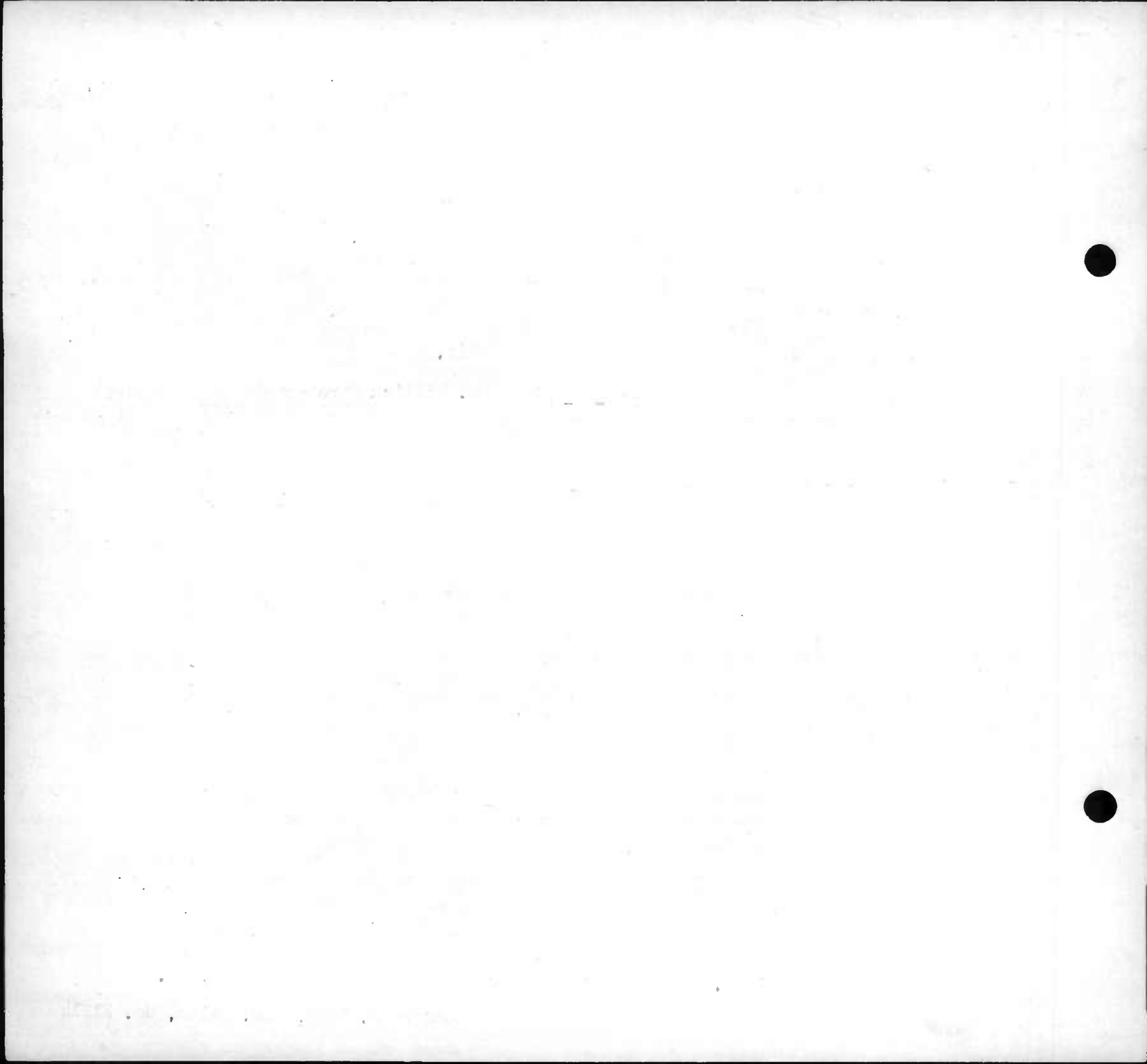
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1395

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 1395

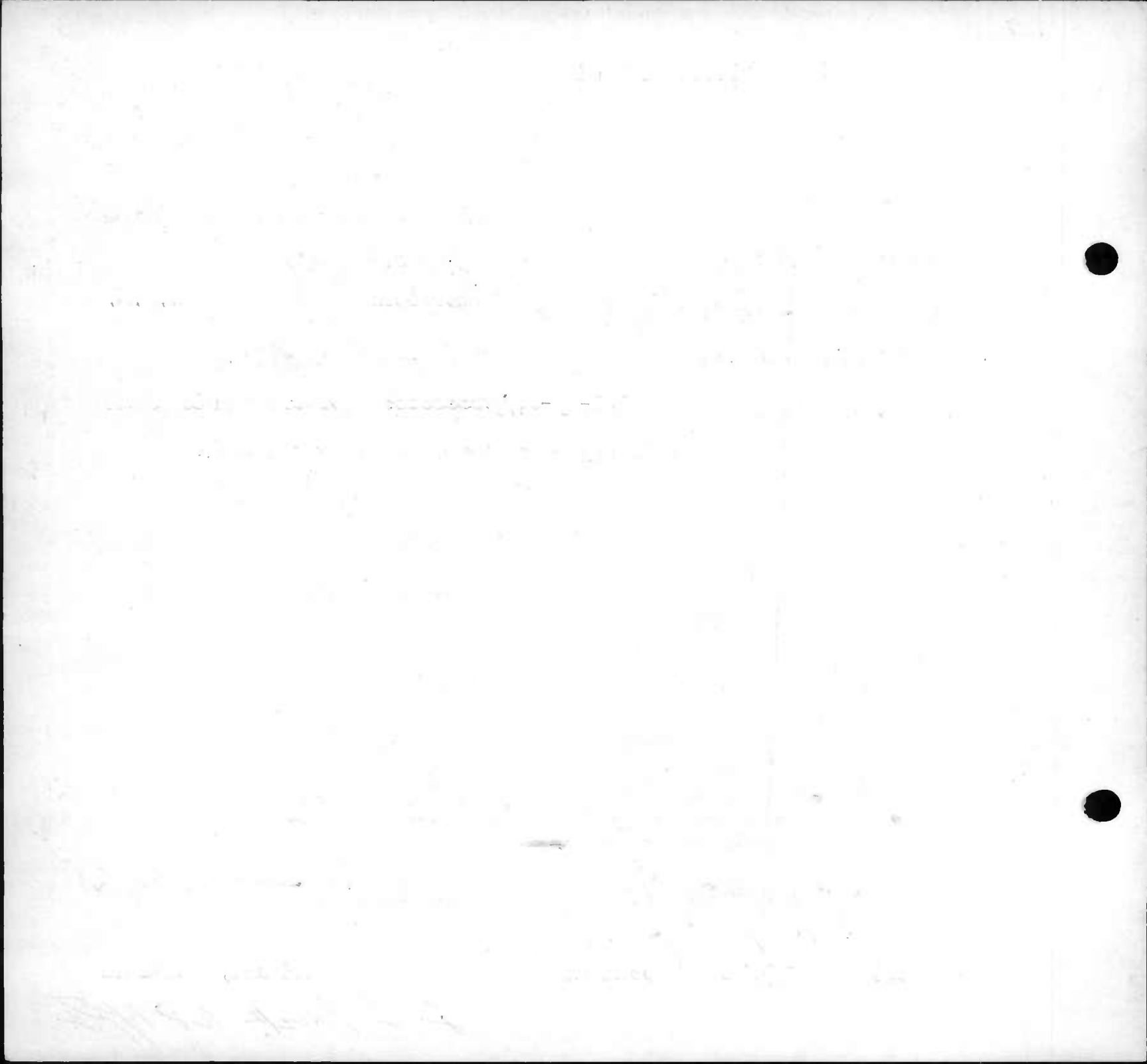
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Mrs. Florence R. Stroterhoff</i>		2. DATE AND HOUR OF DEATH <i>2/3/68 6 A.M. M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>27-34</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>34 Bon Secours Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>3604 Frankford Ave.</i>					
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-16-95</i>	9. AGE (In years lost birthday) <i>73</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Walter Hevern</i>		14. MOTHER'S MAIDEN NAME <i>Eliz. Cook</i>		12. CITIZEN OF WHAT COUNTRY? <i>American</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-28-4654</i>		17. INFORMANT <i>Mr. William Stroterhoff</i> Deceased	
ADDRESS (Same)					
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>A.S.C.V.D. with infarction of myocardium</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>years.</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>420.1 II</i>					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>yes</i>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1/14/68</i> 19 to <i>2/3/68</i> 19, that (I) (we) last saw the deceased alive on <i>2/3/68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Mohamadi</i>				23B. DATE SIGNED <i>2/3/68 6 a.m.</i>	
23C. PHYSICIAN'S NAME (Type) <i>M. MOHAMADI</i>		23D. ADDRESS <i>Bon Secours Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>2/6/68.</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>Feb 6 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Parker, M.D.</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc. Balto. Md. 21214</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1396	
68-1396 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Ms. Pinkney L Davis</i>		2. DATE AND HOUR OF DEATH <i>2/3/68 3:30 p.m.</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>27-38</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Maryland General</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>1536 Sheffield Road</i>	
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/2/08</i>	9. AGE in years (last birthday) <i>59</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Regular - Gen. Electric Co</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Henry Davis</i>		14. MOTHER'S MAIDEN NAME <i>Eligand Norris</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown; if yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-05-6473XXXX</i>		17. INFORMANT <i>Myrtle N Davis</i> ADDRESS <i>Same</i>	
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Probably acute myocardial infarction</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Infarction</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>420.1 II</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (this hospital) attended the deceased from <i>2/3/68</i> to <i>2/3/68</i> , that (we) last saw the deceased alive on <i>2/3/68</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view the body after death.			
23A. SIGNATURE <i>J. Rosemond, M.D.</i> DEGREE		23B. DATE SIGNED <i>2/3/68</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <i>D.R.A.A. SPIER</i> DEGREE		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>2/7/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Woodlawn</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>FEB 5 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>	
25C. FUNERAL DIRECTOR <i>F. I. Burk, R.V. 1772</i>		ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death was: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1397

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-1397

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

~~RAY~~ CONNOR, Raymond C.

2. DATE AND HOUR OF DEATH

2-4-68 5:40 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

44 UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

DOES IT EXCEED CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

HARFORD ROAD, 5224

5. SEX

Male

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

12-07-88

9. AGE (In years last birthday)

79

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

RETIRED CARPENTER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

NEW JERSEY U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

HERBERT NORRIS CONNOR

14. MOTHER'S MAIDEN NAME

FRANCES THATCHER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no at unknown) (If yes, give war at dates of service)

No

16. SOCIAL SECURITY NO.

215-18-9263

17. INFORMANT

Mrs Arabella A Connor Same

ADDRESS

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

Pneumonia

(B) DUE TO, OR AS A CONSEQUENCE OF:

CVA

(C)

Diabetes mellitus

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

260X II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-27-1968 to 2-4-1968, that (I) (we) last saw the deceased alive on 2-4-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Saravut Srifuenfong, M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

2-4-68

23C. PHYSICIAN'S NAME

SARAVUT SRIFUENGFUNG

23D. ADDRESS THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

2/7/68

24C. NAME of CEMETERY or CREMATORY

St John's

24D. LOCATION

Hydes

(City, town, or county)

Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

FEB 5 1968

25B. NAME OF REGISTRAR

Club E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Leonard J Ruck Inc Baltimore Md

ADDRESS

Handwritten text, possibly a date or reference number.

Handwritten text, possibly a date or reference number.

Handwritten text, possibly a date or reference number.

Handwritten text, possibly a date or reference number.

Handwritten text, possibly a date or reference number.

Handwritten text, possibly a date or reference number.

Handwritten text, possibly a date or reference number.

Handwritten text, possibly a date or reference number.

Handwritten text, possibly a date or reference number.

Handwritten text, possibly a date or reference number.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FREDERICK M DIMATTEI				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> February 3, 1968 5:10 P. M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL (DOA)				3. DATE PRONOUNCED DEAD Month Day Year Hour February 3, 1968 5:10 P. M.			
6. SEX Male		7. RACE White		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH May 25, 1915		10. AGE (In years last birthday) 52?		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF U.S.A.		13. FATHER'S NAME Charles DiMattei	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				14B. KIND OF BUSINESS OR INDUSTRY Dairy		15. MOTHER'S MAIDEN NAME Anna Schmidt	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) Yes				17. SOCIAL SECURITY NO. 215-10-2314		18. INFORMANT ADDRESS Mrs Margaret A DiMattei Same	
19. E81210 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple Injuries				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street			
22D. TIME OF INJURY (APPROX.) 2 3 1968 4:25 P. M.				22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR? Truck-truck collision				22G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Ready Avenue and Greenwood			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				21. AUTOPSY? (Yes or No) Yes			
ACTUAL SIGNATURE Werner U. Spitz, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2-4-68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/7/68		24C. NAME OF CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		25B. NAME OF REGISTRAR Robert E. Fawcett		25C. FUNERAL DIRECTOR ADDRESS Leonard J Ruck Inc Baltimore Md.			

WALTER

10/17/73

10/17/73

FUNERAL DIRECTOR: IMPORTANT

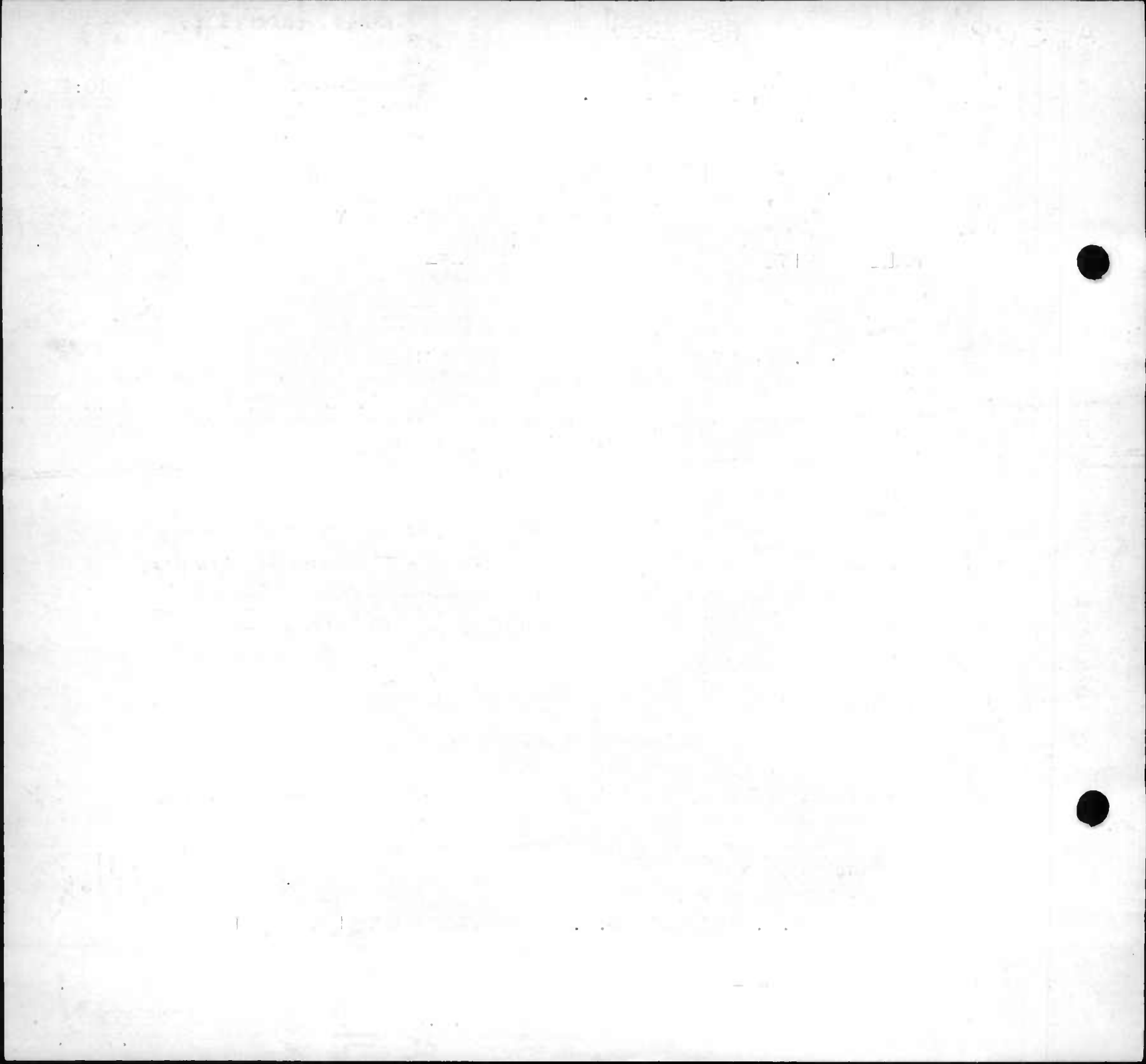
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1399

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

ATHEY, CHARLES E. REG. NO. 68-1399

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ATHEY, CHARLES E.		2-3-68 10:20A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205			MARYLAND ANNE ARUNDEL		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			SEVERNA PARK		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER		
			ROUND BAY BOX 8 52-00		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2-5-08	59	ATTORNEY
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
LAW			MARYLAND	USA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
THOMAS B. ATHEY			AVARILLA EDWARDS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
NO			WILLIAM B. ATHEY 215 UPNOR RD., BALTO.		
18. 396.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH Cardiac arrest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) RHD = MS + AIZ, APB + slow vent. Depression = 2 indwelling pacemakers (C) ASCVD = past Hx MI		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
410X II				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from 2/1/68 to 2/3/68, that (X) (we) last saw the deceased alive on 2/3/68 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H.M. MEAGHER				23B. DATE SIGNED 2/3/68	
23C. PHYSICIAN'S NAME (Type) H.M. MEAGHER M.D.				23D. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county)	(State)
BURIAL		2-6-68	LOUDON PARK	BALTIMORE	MD.
25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		25B. NAME OF REGISTRAR Helen E. Farley		25C. FUNERAL DIRECTOR ADDRESS H.W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1400

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

REG. NO.

68- 1400

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Mueller, William H.</i>		2. DATE AND HOUR OF DEATH <i>2/6/68 2:00 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Balt. City</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>44 Union Memorial Hosp.</i>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <i>Balt.</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>Roland Park Apts 27-14</i>		5. SEX <i>M</i> 6. RACE <i>W</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1-28-84</i> 9. AGE (In years last birthday) <i>84</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>EXECUTIVE BANKING</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>William Mueller</i>		14. MOTHER'S MAIDEN NAME <i>Johanna Cortes</i>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no of unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-18-9336</i>		17. INFORMANT <i>son</i> ADDRESS <i>206 Woodland Rd</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>410.9 I</i> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiac Arrest (Ventric. Fib.)</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial Infarction</i> (C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1/29</i> 19 <i>68</i> to <i>2/4</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>2/4</i> 19 <i>68</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>B. Weckesser, M.D.</i>				23B. DATE SIGNED <i>2/4/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>BARRY J WECKESSER M.D.</i>		23D. ADDRESS <i>THE UNION MEMORIAL HOSPITAL Union Memorial Hosp</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Entombment</i>		24B. DATE <i>2-6-68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park</i>	
24D. LOCATION (City, town, or county) <i>Baltimore</i>		24E. STATE <i>Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>FEB 5 1968</i>	
25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR ADDRESS <i>H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md.</i>			

1904

1904

84

Harvard

Johns Hopkins

84

Constitution

Presidential

W. W. W.

William W. W.

1904

84

1904

X

Union

1904

W. W. W.

William W. W.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Death was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

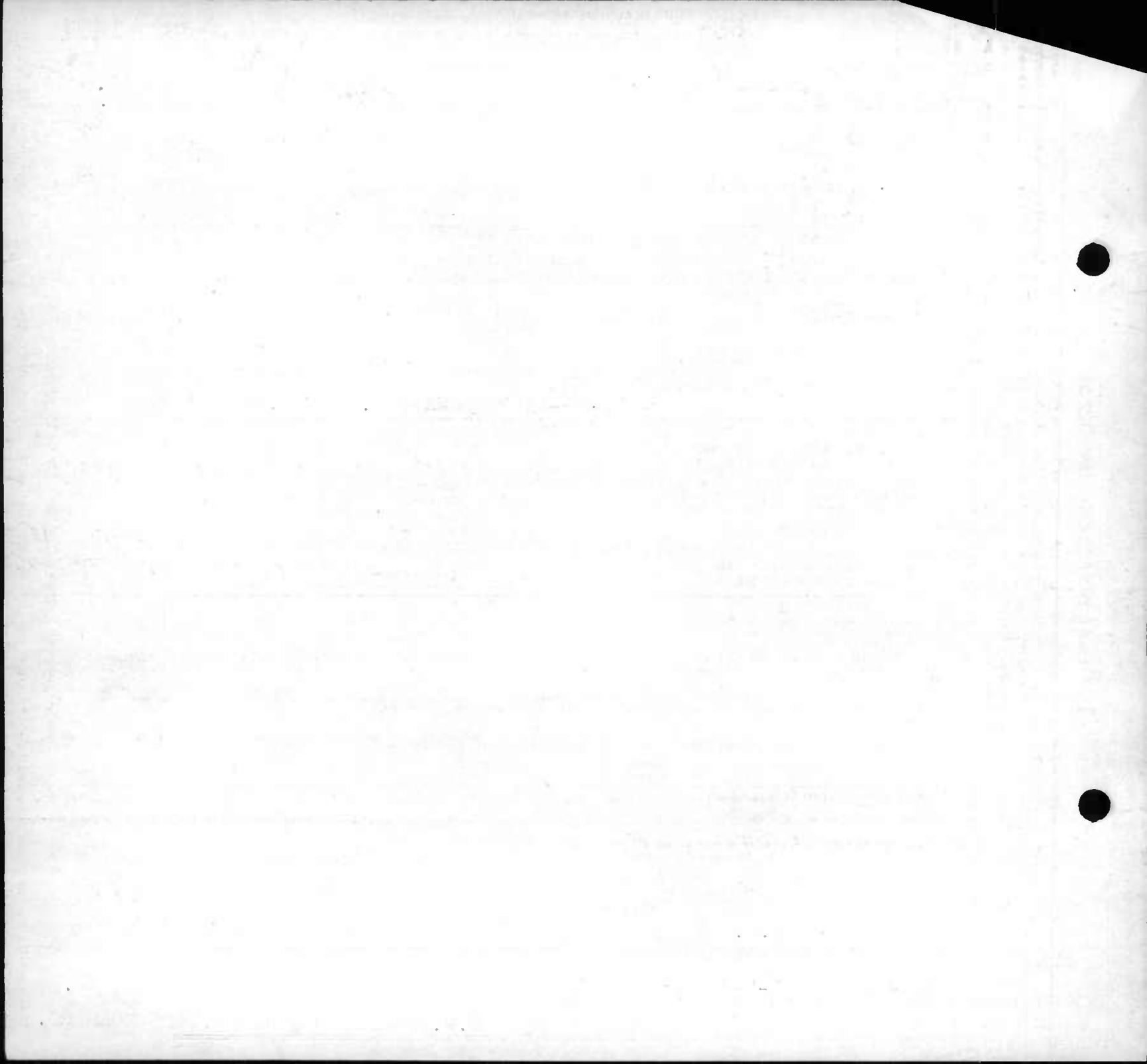
68- 1401

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 1401

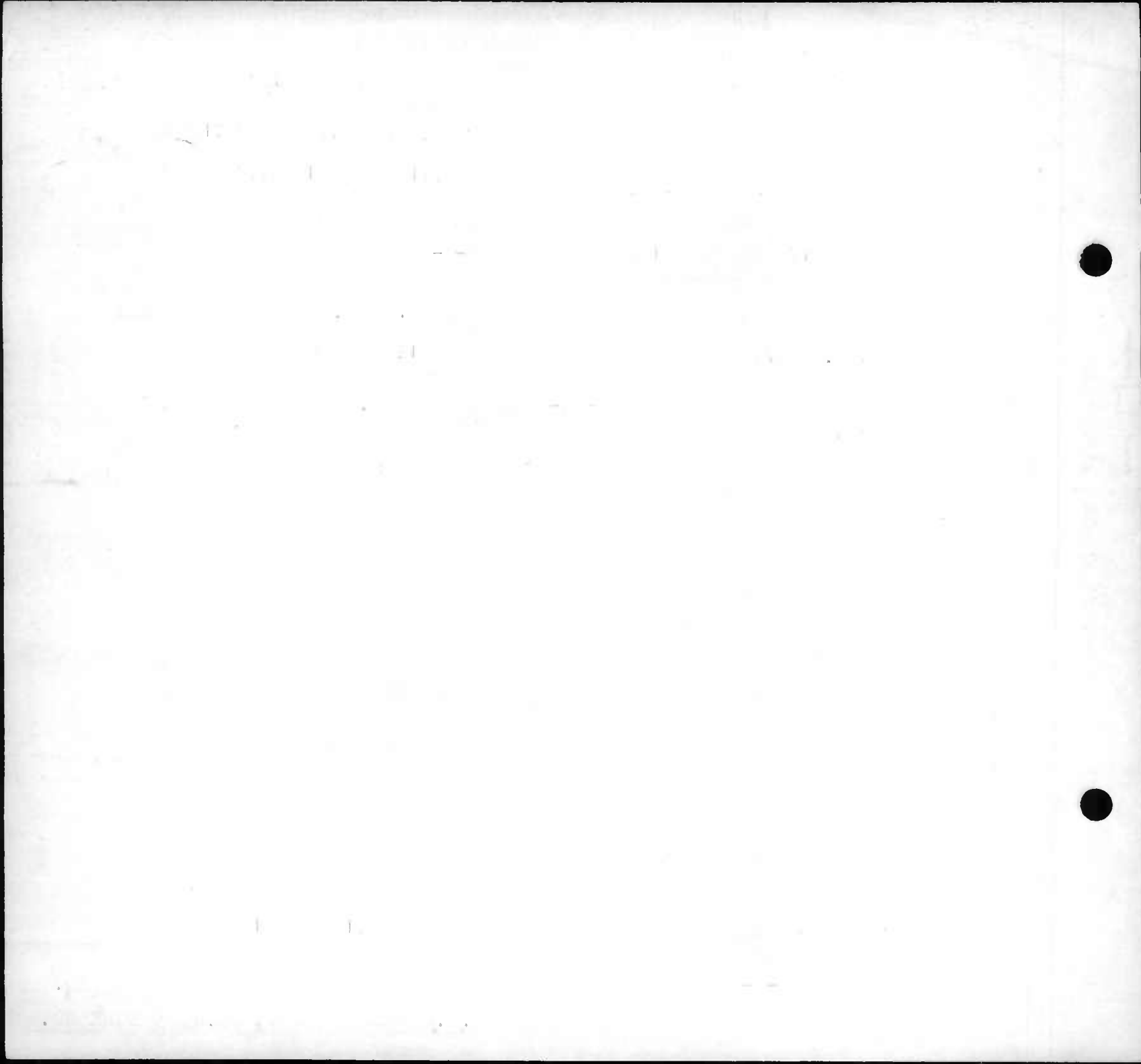
BIRTH NO.		1. NAME OF DECEASED (Type or Print) STELLA M. ATKINSON		2. DATE AND HOUR OF DEATH 2/2/68 5:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL 33			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE COUNTY C. CITY OR TOWN LUTHERVILLE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 7202 CHARLES STREET 53-00		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-1-23	9. AGE (In years last birthday) 44	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) LONDON, ENGLAND	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME ARTHUR MACMIN		
14. MOTHER'S MAIDEN NAME CONSTANCE TAYLOR			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 212-50-1307		17. INFORMANT EDWARD J. ATKINSON		ADDRESS SAME	
18. 174 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: METASTASIS OF BREAST CARCINOMA TO BRAIN, LIVER AND OTHER ARRS. (B) CARCINOMA OF BREAST DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 6 yrs ago		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 170 X II					
19A. DATE OF OPERATION 1/4/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED HE BREAST METASTATIC CA		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input type="checkbox"/>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from 1/1 19 68 to 2/2 19 68 , that (I) (we) last saw the deceased alive on FEB 2 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes noted above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S.H. BENNETT MD.				23B. DATE SIGNED 2/2/68	
23C. PHYSICIAN'S NAME (Type) S.H. BENNETT		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 2-5-68		24C. NAME OF CEMETERY or CREMATORY GREENMOUNT	
24D. LOCATION BALTIMORE		24E. (City, town, or county) (State) MD.			
25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		25B. NAME OF REGISTRAR Robert E. Feltz		25C. FUNERAL DIRECTOR H.W. JENKINS & SONS CO. 4905 YORK RD.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 68-1402	
68-1402				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		KATHERINE H. NAENY		FEB. 2, 1968 9.00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL		A. STATE MARYLAND B. COUNTY CITY OF BALTIMORE			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE IN CITY			
		D. STREET ADDRESS (If rural, give location) 5203 FALLS ROAD			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 12-3-02	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTO., MD.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ALBERT F. HOLTZ		14. MOTHER'S MAIDEN NAME NELLIE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 705-05-4878		17. INFORMANT ALBERT H. NAENY	
				ADDRESS SAME	
18. 200.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Lymphosarcoma (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 5 years	
19. 200.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JAN 29 19 68 to FEB 2 19 68, that (I) (we) last saw the deceased alive on FEB. 2 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Benjamin Lechner, M.D.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Feb 2, 1968	
23C. PHYSICIAN'S NAME (Type) BENJAMIN LECHNER		23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 2-5-68		24C. NAME OF CEMETERY or CREMATORY GREENMOUNT	
24D. LOCATION (City, town, or county) (State) BALTIMORE MD.		25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		25B. NAME OF REGISTRAR R. E. Taylor	
25C. FUNERAL DIRECTOR H.W. JENKINS & SONS CO.		4905 YORK RD.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, the body was released to the hospital by a medical examiner. Also, if the direct or contributory cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Death was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1403

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

REG. NO.

68- 1403

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ALVIN SEIM, ALVINIA KATHERINE		2. DATE AND HOUR OF DEATH 2-2-1968 12:40 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 UNION MEMORIAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		C. CITY OR TOWN BALTIMORE	
5. SEX Female		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 10-15-91		9. AGE (In years last birthday) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Seim	
14. MOTHER'S MAIDEN NAME Katherine Repp		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-05-1852A	
17. INFORMANT patient transformation (Harford Garden)		18. CAUSE OF DEATH 493X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the underlying condition last. 241X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-2-68 to 2-2-1968 , that (I) (we) last saw the deceased alive on 2-2-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Saravut Srifuegfung, M.D.				23B. DATE SIGNED 2-2-68	
23C. PHYSICIAN'S NAME (Type) DR. SARAVUT SRIFUEGFUNG				23D. ADDRESS THE UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-5-68		24C. NAME OF CEMETERY OR CREMATORY St. Pauls Lutheran	
24D. LOCATION (City, town, or county) Baltimore		24E. STATE Md.		25A. DATE RECEIVED BY HEALTH DEPT. FEB 5 1968	
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25D. ADDRESS 4905 York Rd.	

10-11-11

Katherine

John Lane

10-11-11

John Lane

John Lane

John Lane

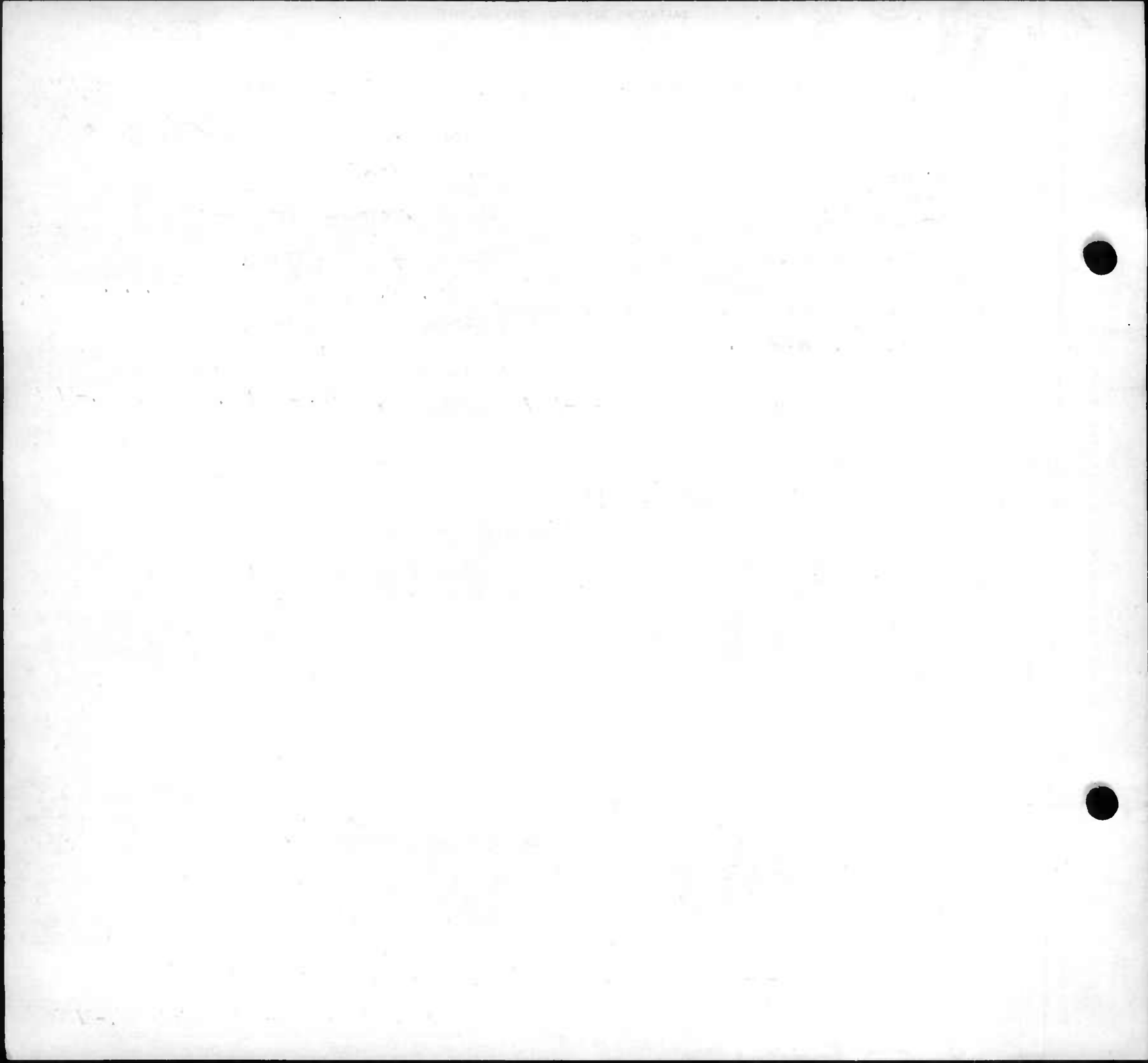
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1404

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-1404

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MOORE PAUL L. Jr.		2. DATE AND HOUR OF DEATH 2/2/1968 7:40 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY S. D. 3			
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL OF MARYLAND		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER East Hoffman St 2401					
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/19/14	9. AGE (In years last birthday) 53 YRS	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10B. KIND OF BUSINESS OR INDUSTRY Yellow Cab Company		11. BIRTHPLACE (State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Paul L. Moore Sr.		14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) Yes		16. SOCIAL SECURITY NO. 219-03-1441		17. INFORMANT Myrtle B. Moore -2401 E. Hoffman St. -21213	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Acute Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: (B) due to coronary thrombosis DUE TO, OR AS A CONSEQUENCE OF: (C) due to atherosclerotic cardiovascular disease			
19. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from 2/1/68 19 to 2/2/68 19, that (I) was last saw the deceased alive on 2/2/68 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death.					
23A. SIGNATURE P. P. JOSHI		MD. DEGREE M.D.		23B. DATE SIGNED 2-2-68	
23C. PHYSICIAN'S NAME (Type) P. P. JOSHI		23D. ADDRESS 730 ASHBURTON ST; BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-6-68		24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		25B. NAME OF REGISTRAR John C. Miller Inc		25C. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Rd. -21206	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1405

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-1405

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Andrew Diffendall

2. DATE AND HOUR OF DEATH

February 2, 1968 5:18 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

60 4207 Glenmore Avenue

4. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN
Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

4207 Glenmore Avenue

5. SEX

Male

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

June 1, 1892

9. AGE (In years
last birthday)

75

If Under 1 Yr.
Months: DaysIf Under 24 Hrs.
Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Tool crib

10B. KIND OF BUSINESS OR INDUSTRY

Dept. of Education

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Henry Diffendall

14. MOTHER'S MAIDEN NAME

Margaret A. Burke

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

215-03-5839

17. INFORMANT

Bessie May O'Neill - 4207 Glenmore Ave.

ADDRESS

18. 736.9 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last,

CAUSE OF DEATH

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

Central accident

24 hrs

(B) ~~Myocardial infarction~~
DUE TO, OR AS A CONSEQUENCE OF:

5 yrs

(C) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

331X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (Indicate medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

1 Month (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1958 to 212 1968.
that (I) (we) last saw the deceased alive on 2/1 1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Conrad L. Richter

OEGREE

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

2/2/68

23C. PHYSICIAN'S
NAME (Type)

Conrad L. Richter

OEGREE

23D. ADDRESS

3128 Harford Rd. Baltimore, Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

2-5-68

24C. NAME of CEMETERY or CREMATORY

Mt. Olivet Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

FEB 5 1968

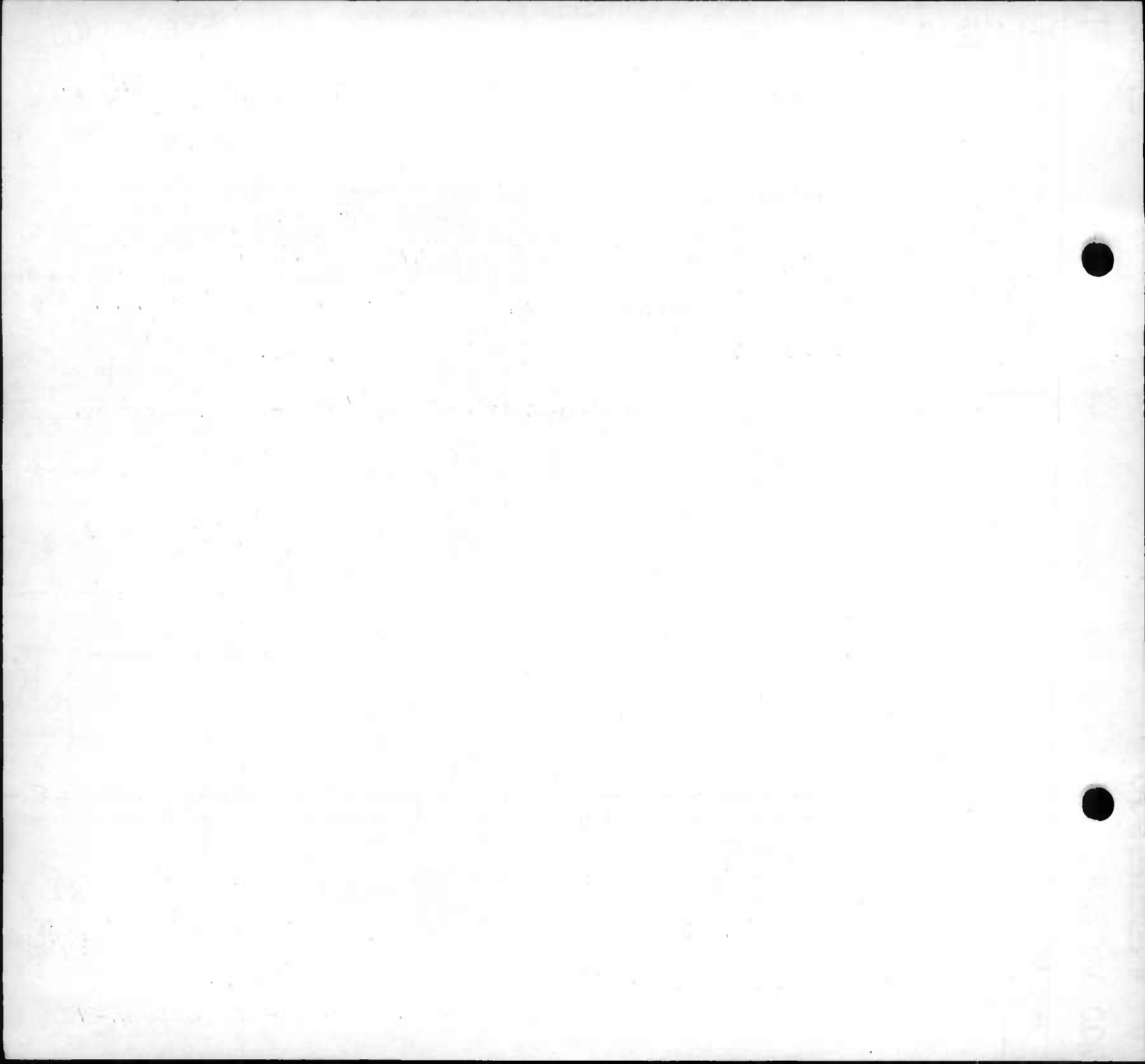
25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

John C. Miller Inc-6415 Belair Rd.-21206

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

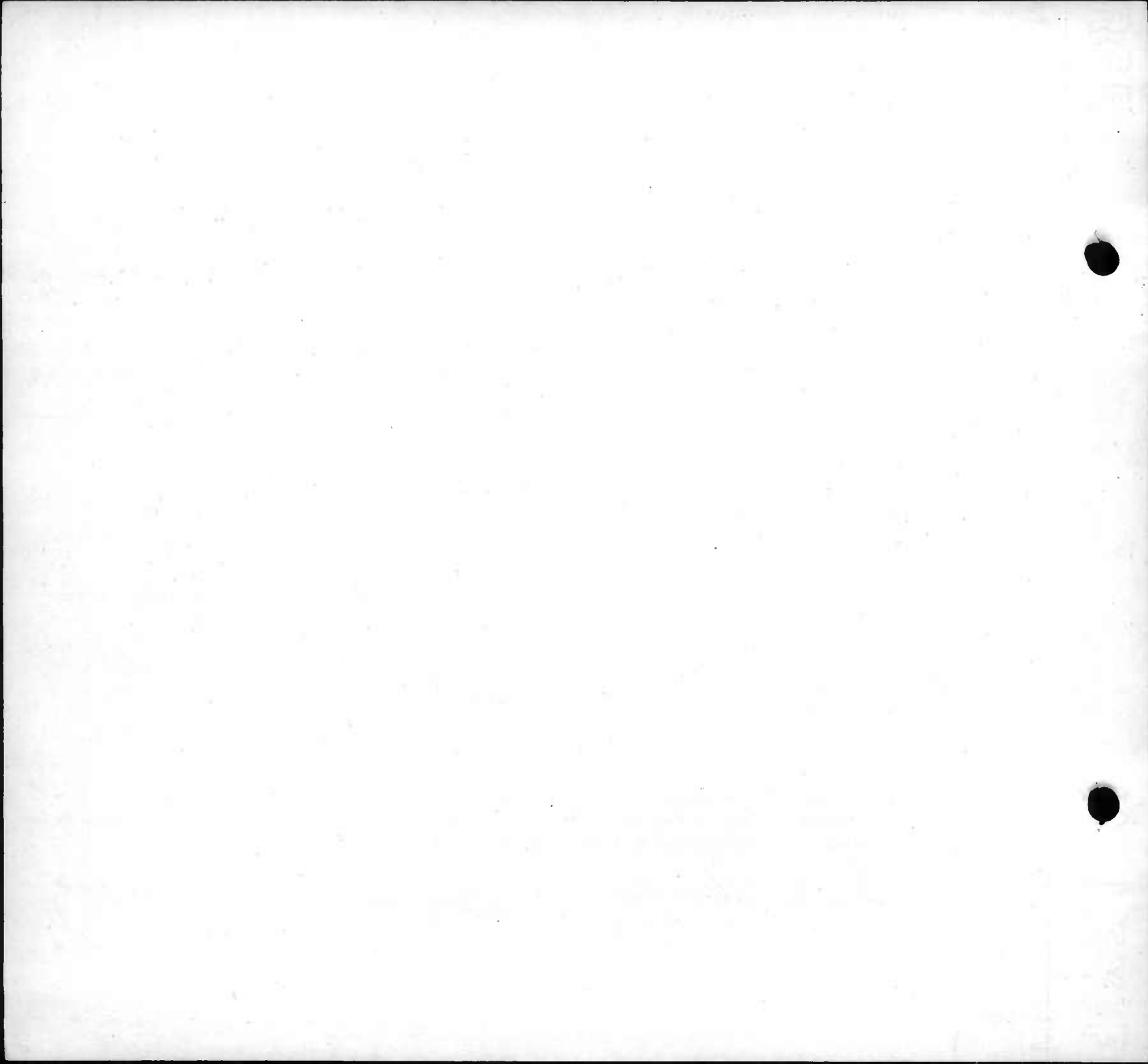
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1406

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 1406

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MANUEL SOLLA		2. DATE AND HOUR OF DEATH 2-2-68 9:35 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 MARY LAND GENERAL				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY 12-07 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2625 HUNTINGDON AVE	
5. SEX MALE	6. RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-05-93	9. AGE (In years last birthday) 74	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - U.S. Gov.			10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) SPAIN
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME A. SOLLA		
14. MOTHER'S MAIDEN NAME UNKNOWN			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 418-22-0307			17. INFORMANT FORM. Admission		
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Route MI DUE TO, OR AS A CONSEQUENCE OF: (B) ASCVD DUE TO, OR AS A CONSEQUENCE OF: (C) —				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH day years	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2-1 19 68 to 2-2 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2-2 19 68 and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.					
23A. SIGNATURE C. S. Rife				23B. DATE SIGNED 2-2-68	
23C. PHYSICIAN'S NAME (Type) Charles E. Rife				23D. ADDRESS MARYLAND GENERAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/6/68		24C. NAME OF CEMETERY or CREMATORY Meadowridge	
24D. LOCATION (City, town, or county) (State) Wash Blvd, Md		25A. DATE REC'D BY HEALTH DEPT. Feb 8 1968			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Christine E. Donovan - 3818 Roland Ave			



1
D-256

68-1407 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

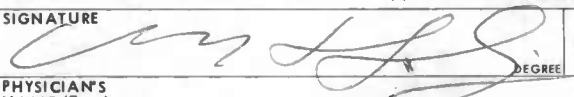
REG. NO. 68-1407

BIRTH NO.

1. NAME OF DECEASED (Type or Print) THOMAS H. DEGENHARD		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> February 1, 1968 11:10 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 826 W. 35th St.		3. DATE PRONOUNCED DEAD Month Day Year Hour February 2, 1968 12:04 P.M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
9. DATE OF BIRTH 9/17/89		10. AGE (In years lost birthday) 78	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Watchman		14B. KIND OF BUSINESS OR INDUSTRY Balmar Corp	
15. MOTHER'S MAIDEN NAME Mollie L. Gray		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO. 213106737		18. INFORMANT Ada I. Turnbull	
19. CAUSE OF DEATH 412.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2/6/68		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. EXAMINER'S NAME (Type)	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/6/68	
24C. NAME of CEMETERY or CREMATORY Baltimore		24D. LOCATION (City, town, or county) (State) E. North Ave, Md	
25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Austin E. Donovan		ADDRESS 3818 Roland Ave	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				68-1408		68-1408	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JONES, JAMES OLIMER SR.				2. DATE AND HOUR OF DEATH FEBRUARY 02, 1968 7:05A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD ST AGNES HOSPITAL WILKENS AND CATON AVENUE BALTIMORE MARYLAND 21229				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 21229 Baltimore Co			
5. SEX MALE 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 03/11/92 9. AGE (In years last birthday) 75			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POLICEMAN				10B. KIND OF BUSINESS OR INDUSTRY POLICE DEPT		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME CHARLES JONES				14. MOTHER'S MAIDEN NAME Emma (Unknown)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 212-32-9796		17. INFORMANT ADDRESS ST AGNES HOSPITAL WILKENS & CATON AVE	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) POORLY differentiated CARCINOMA.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). PLEURAL EFFUSION DUE TO METASTASIS							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JAN 18 19 68 to FEB 02 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on FEB 02 19 68 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (XXX) view the body after death.							
23A. SIGNATURE 						23B. DATE SIGNED 2-2-68	
23C. PHYSICIAN'S NAME (Type) O. LABORDA, M.D.				23D. ADDRESS ST AGNES HOSPITAL WILKENS & CATON AVE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-6-1968		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. FEB 6 1968		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 68-1409	
68-1409				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		LAWSON, MADELINE P.		FEBRUARY 1, 1968 2:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL				A. STATE MARYLAND	
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) JENKINS MEMORIAL HOSPITAL-CATON AVE.	
				D. STREET ADDRESS (If rural, give location) Caton Avenue 25-41	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOW	8. DATE OF BIRTH 10-09-82	9. AGE (In years last birthday) 85	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME PHILLIP PANTEL				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. MOTHER'S MAIDEN NAME FRANCES HITZEBERGER				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE	
16. SOCIAL SECURITY NO. 217-48-5919		17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 157.0 I Acute Granuloma				CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				14 -	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 157X II Liver metastases - Ca sigmoid				5 y.	
19A. DATE OF OPERATION Feb 1/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca. Head of the brain		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initial medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JANUARY 28 19 68 to FEBRUARY 1 19 68 , that (I) (we) last saw the deceased alive on FEBRUARY 1 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Alejandro Mejia</i>				23B. DATE SIGNED 2-1-68	
23C. PHYSICIAN'S NAME (Type) ALEJANDRO MEJIA				23D. ADDRESS M.D. CATON AND WILKENS AVE. BALTIMORE MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-5-68		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland		25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968			
25B. NAME OF REGISTRAR <i>Robert E. Farber</i>		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229			

2:30P

ST. LOUIS 121001

ST. LOUIS 121001

10-8-1

10-8-1

0.7.7.1

0.7.7.1

0.7.7.1

ST. LOUIS 121001

ST. LOUIS 121001

ST. LOUIS 121001

ST. LOUIS 121001

ST. LOUIS 121001

ST. LOUIS 121001

ST. LOUIS 121001

ST. LOUIS 121001

ST. LOUIS 121001

91 54 04
PARKS, MARY R.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1410	
CERTIFICATE OF DEATH					
BIRTH NO. 1		2		3	
1. NAME OF DECEASED (Type or Print) MARY R. PARKS		2. DATE AND HOUR OF DEATH. 2/4/68 120 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 6-02			
FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 235 N. Luzerne Avenue		5. AGE (In years last birthday) 76 yrs.			
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 12/18/91		9. AGE (In years last birthday) 76 yrs.		10. Under 1 Yr. Months: Days: 10. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME CARTER, CORTLEY			
14. MOTHER'S MAIDEN NAME PARKS, LIZA JANE		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. 230.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Diabetic Ketoacidosis (B) Diabefes mellitus, DUE TO, OR AS A CONSEQUENCE OF: (C) Multiple cerebral yasc. accidents		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hrs.	
19. DATE OF OPERATION 260 X II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/21/68 to 2/4/68, that (I) (we) lost saw the deceased alive on 2/4/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.					
23A. SIGNATURE David J. SNAW, MD		23B. DATE/SIGNER 2/4/68		23C. PHYSICIAN'S NAME (Type) DAVID J. SNAW, MD	
23D. ADDRESS Johns Hopkins Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 2-7-68		24C. NAME OF CEMETERY OR CREMATORY Bald Rock Cemetery		24D. LOCATION (City, town, or county) (State) Flatridge, Va.	
25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard Funeral Home Inc. 4107 Wilkens Ave. Baltoe 21229	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1411 BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 68- 1411	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) CARL GIBSON		2. DATE AND HOUR OF DEATH 2-22-68 5:35 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY 25-04			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 36 FRANKLIN SQUARE HOSPITAL				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 4420 OLD FREDERICK ROAD			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-9-94	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME SAMUEL GIBSON				14. MOTHER'S MAIDEN NAME MARGARET ADDISON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W I			16. SOCIAL SECURITY NO. 25036269		17. INFORMANT FRANKLIN SQUARE HOSPITAL		ADDRESS HOSPITAL
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CA LONG & DISTANT (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: METASTASIS CNF ASCVD (B) DUE TO, OR AS A CONSEQUENCE OF: PNEUMONITIS (C) 163X II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SEV. YEARS 1-2 WKS			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1-26 19 68 to 2-2 19 68 , that (I) (we) last saw the deceased alive on 2-2 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ruben V. Luna MD				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 2-2-68	
23C. PHYSICIAN'S NAME (Type) RUBEN V. LUNA				23D. ADDRESS FRANKLIN SQUARE HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-6-1968		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		25B. NAME OF REGISTRAR Robert E. Tarkenton		25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-1412

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Nicholas Diakouloukas</i>		2. DATE AND HOUR OF DEATH <i>1-30-68 1 A. M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>21224</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>North Charles General Hosp.</i>		E. STREET AND NUMBER <i>632 South Ubra St.</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-16-37</i>	9. AGE (In years last birthday) <i>30</i>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Self Employed Terminal Bar</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Grease</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Diakouloukas</i>		14. MOTHER'S MAIDEN NAME <i>Despina</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>N. C. H. H. Chart</i>	
18. <i>582X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Uremia</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Chronic Glomerulonephritis</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>-</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>592X II</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1-22-</i> 19 <i>68</i> to <i>1-30-</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>1-30-</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Fernando de la Torre</i>		23B. DATE SIGNED <i>1-30-68</i>		23C. PHYSICIAN'S NAME (Type) <i>GERMAN DE LA TORRE</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>2/2/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Greek Orthodox Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>FEB 5 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairbank</i>	
25C. FUNERAL DIRECTOR <i>Matthews Funeral Home</i>		ADDRESS <i>Easton Ave. Baltimore, Md.</i>			

1897
X
The text
of the
document
is
very
faint
and
illegible
in
many
places.
The
date
is
1897.
The
text
is
very
faint
and
illegible
in
many
places.
The
date
is
1897.
The
text
is
very
faint
and
illegible
in
many
places.
The
date
is
1897.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

68-1413

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

EDWARD J. MCKEOWN

2. DATE AND HOUR OF DEATH

FEB. 3/68
2-3-68 9:35 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

FRANKLIN SQUARE HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

3709 THIRD ST. 21205

5. SEX

M

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

10-21-89

9. AGE (In years
last birthday)

78

11. Under 1 Yr.
Months: Days:

If Under 24 Hrs.
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

RETIRED

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

JOHN F. MCKEOWN

14. MOTHER'S MAIDEN NAME

—

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

213-38-6788

17. INFORMANT

ADDRESS

FRANKLIN SQUARE HOSPITAL

18.

5-32-11

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

PERITONITIS

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

36 hrs

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

PERFORATED DUODENAL ULCER

30 hrs.

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

COMPLICATING CONG. HEART

SEV. YRS.

(C) FAILURE DUE TO ASCVD

5-41-1

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from JAN. 28 1968 to FEB. 3 1968.
that (I) (we) lost saw the deceased alive on FEB. 3 1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Ruben V. Luna MD

Attending
Phys. ☐

Med.
Director ☐

Staff
Phys. ☒

23B. DATE SIGNED

2-3-68

23C. PHYSICIAN'S
NAME (Type)

RUBEN V. LUNA MD

23D. ADDRESS

FRANKLIN SQUARE HOSPITAL

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

2/7/68

24C. NAME OF CEMETERY or CREMATORY

Loudon Park

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

FEB 5 1968

25B. NAME OF REGISTRAR

John E. Fairburn

25C. FUNERAL DIRECTOR

McCurly FH. 237 Patapsco Ave. 21225

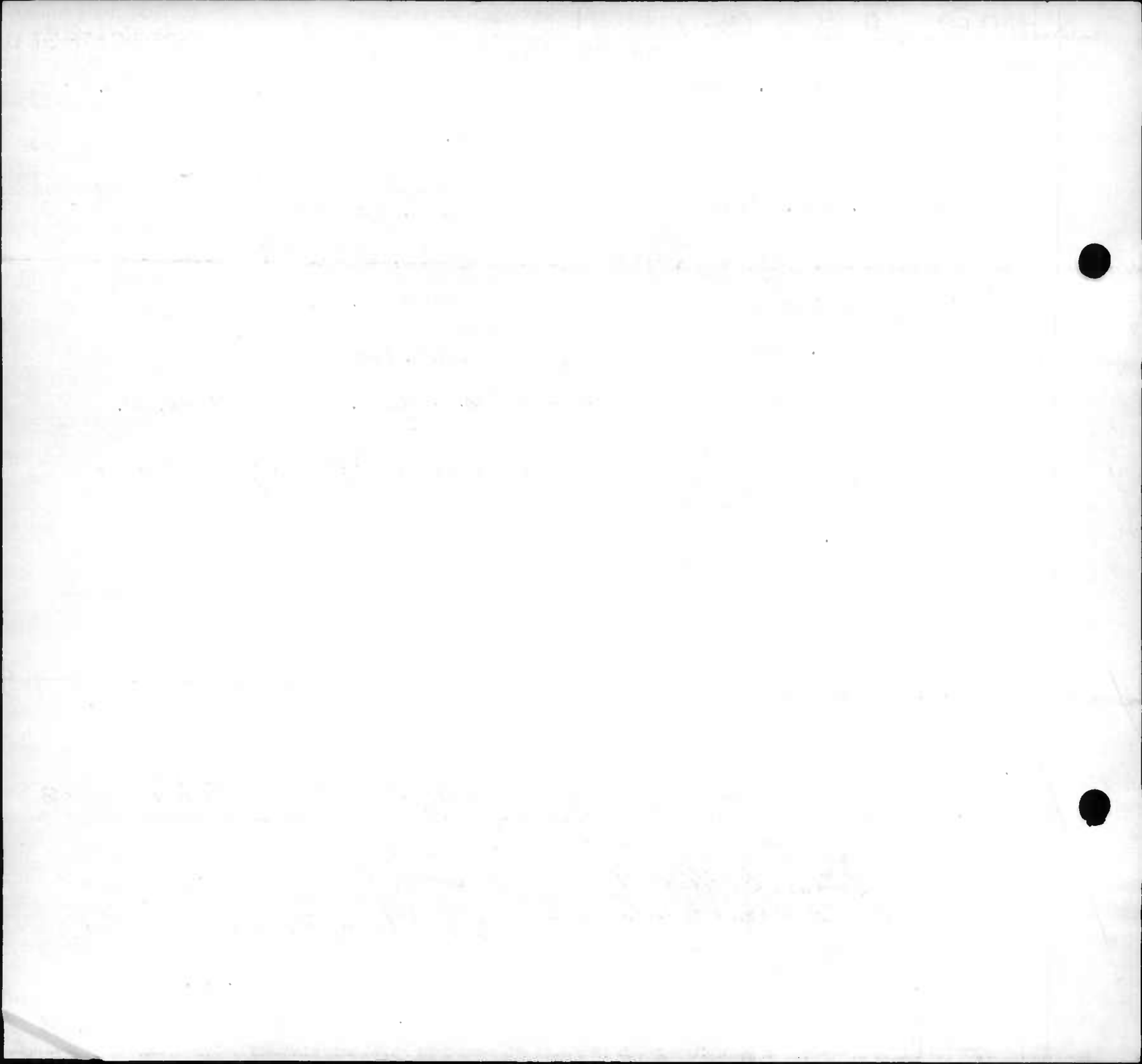
Handwritten text, likely bleed-through from the reverse side of the page. The text is mostly illegible due to fading and bleed-through.

Handwritten text, likely bleed-through from the reverse side of the page. The text is mostly illegible due to fading and bleed-through.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>68-1414</u>
BIRTH NO. <u>68-1414</u>		CERTIFICATE OF DEATH		
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <u>February 1, 1968</u> <u>5 A.M.</u> M.		
1. NAME OF DECEASED (Type or Print) <u>Bond A. Roop</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <u>OD</u> <u>1513 E. 33rd. Street</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		
		D. STREET ADDRESS (If rural, give location) <u>1513 E. 33rd Street</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED, DIVORCED (specify)</u> <u>Married</u>	8. DATE OF BIRTH <u>August 9, 1897</u>	9. AGE (In years last birthday) <u>70</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Franklin P. Roop</u>		
14. MOTHER'S MAIDEN NAME <u>Ida S. Bond</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW 1</u>		
16. SOCIAL SECURITY NO. <u>212-07-7510</u>		17. INFORMANT ADDRESS <u>Mrs. Reatha A. Roop Baltimore, Md.</u>		
18. I <u>162.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) <u>Cancer of left lung</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
163X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION <u>6</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>Nov. 23, 1966</u> to <u>Feb. 1, 1968</u> , that (I) (we) last saw the deceased alive on <u>Jan. 12, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Abraham B. Hurwitz</u> M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>Feb. 1, 1968</u>
23C. PHYSICIAN'S NAME (Type) <u>ABRAHAM B. HURWITZ</u>		23D. ADDRESS M.D. <u>7501 Liberty Rd., Baltimore, Md.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>2/3/68</u>	24C. NAME OF CEMETERY or CREMATORY <u>Emory Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Carroll Co. Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>Feb 5 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Tipton-Eline Funeral Home Hampstead, Md</u>



K-520

68-1415 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-1415

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HARRY W. KING		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> February 1, 1968 Hour 9:15 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour February 1, 1968 9:15 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
9. DATE OF BIRTH April 6, 1905		10. AGE (In years lost birthday) 62	
11. BIRTHPLACE (State or foreign country) Owings Mills, Md.		12. CITIZEN OF USA COUNTRY?	
13. FATHER'S NAME Sylvester V. King		14. STREET AND NUMBER 11124 Reisterstown Road	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Port City Press Company		15. MOTHER'S MAIDEN NAME Minerva Nelson	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 218-22-4016	
18. INFORMANT Miss. Dorothea King		ADDRESS Owings Mills, Md.	
19. 485X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Acute Bronchopneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2/2/68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/5/68	
24C. NAME OF CEMETERY or CREMATORY St Thomas Cemetery		24D. LOCATION (City, town, or county) (State) Owings Mills, Md.	
25A. DATE REC'D BY HEALTH DEPT. EEB 5 1968		25B. NAME OF REGISTRAR J. F. Eline & Sons	
25C. FUNERAL DIRECTOR J. F. Eline & Sons		ADDRESS Reisterstown, Md.	

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

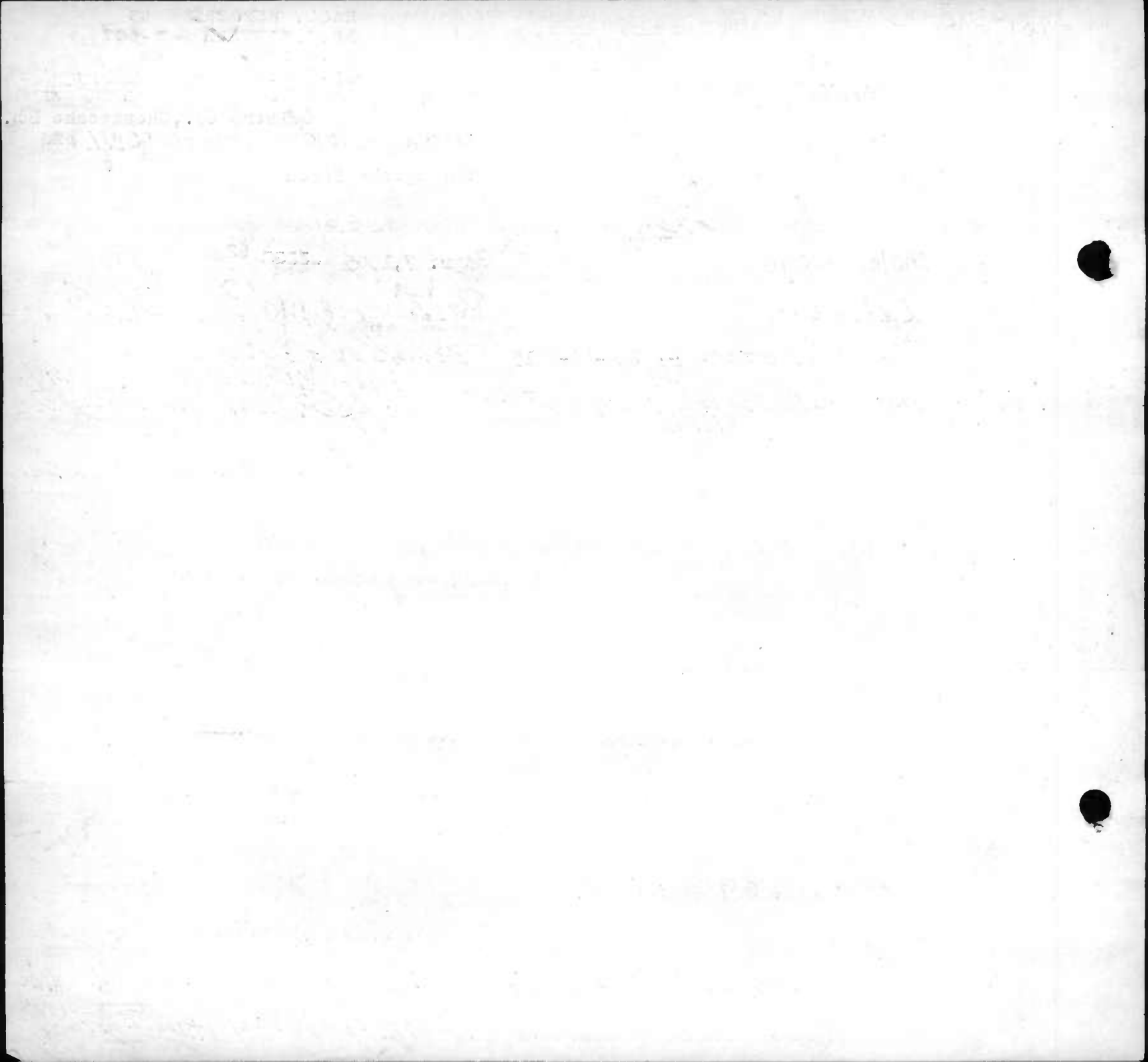
1000

1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

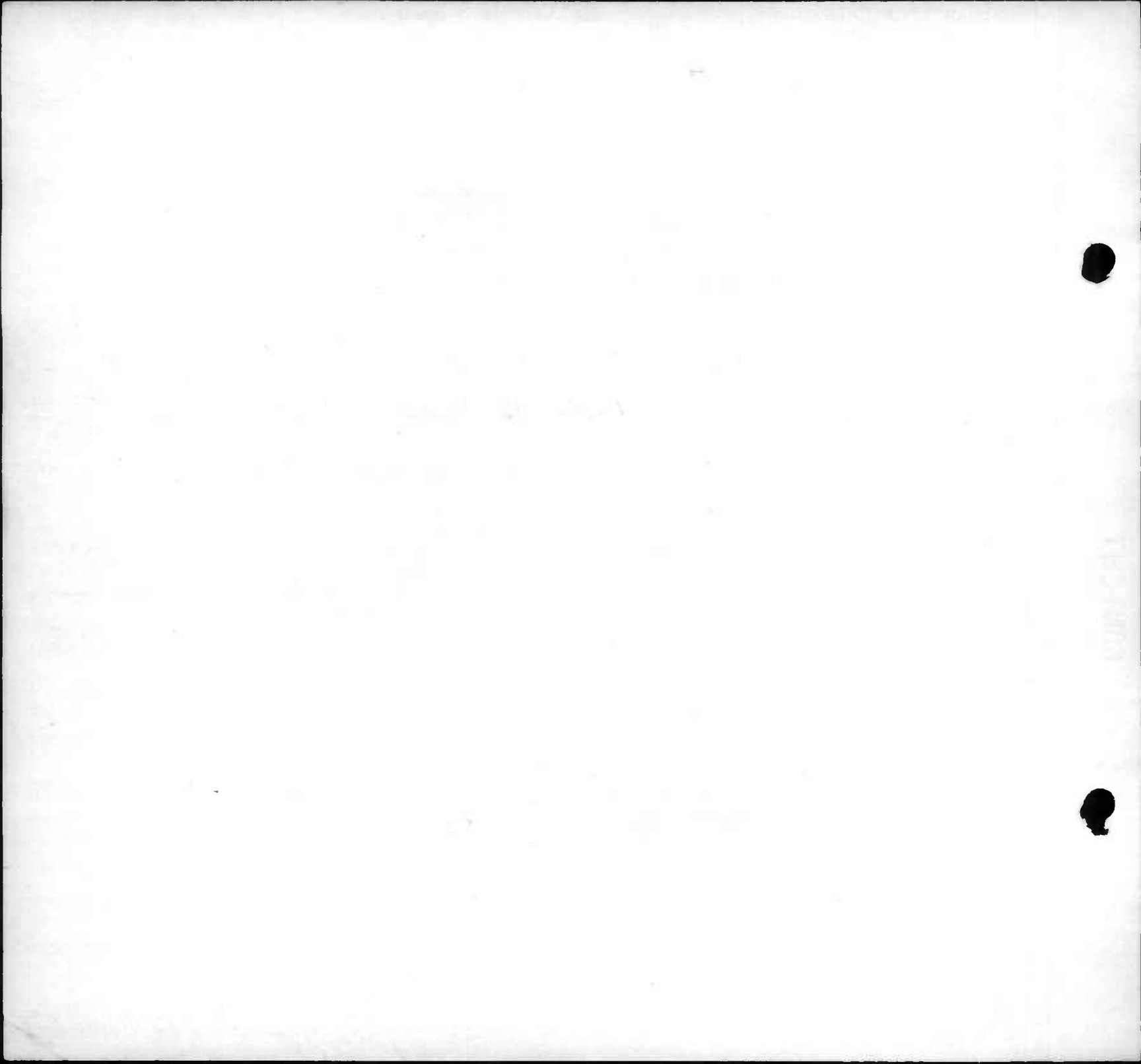
68- 1416				CITY HEALTH DEPARTMENT				REG. NO. 1416			
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>Herbert Hall</u>				2. DATE AND HOUR OF DEATH <u>1/27/68</u> <u>3:40 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Calvert Co.</u> C. CITY OR TOWN <u>Chesapeake Beach</u> D. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				E. STREET AND NUMBER			
FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)							
5. SEX <u>Male</u>		6. RACE <u>Negro</u>		7. <input checked="" type="checkbox"/> MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH <u>Apr. 7, 1905</u>		9. AGE (In years, lost birthday) <u>62</u>		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u> <u>12/21/42 to</u> <u>8/3/45</u>				16. SOCIAL SECURITY NO. <u>214-26-7515</u>				17. INFORMANT <u>Miss Bernice Jefferson Huntington</u>			
18. <u>433.9</u> <u>I</u> <u>8/3/45</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE (B) <u>Modelle Carotid thrombus</u> <u>2 weeks</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Aspiration pneumonia</u> <u>1 week</u> (C) <u>Aspiration pneumonia</u> <u>1 week</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
332X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION <u>1/18/68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Possible Sub-Dural</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (this hospital) attended the deceased from <u>1/17/68</u> <u>1968</u> to <u>1/27/</u> <u>1968</u> , that (we) last saw the deceased alive on <u>1/27</u> <u>1968</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Fredrich P. Smith MD</u>				23B. DATE SIGNED <u>1/27/68</u>							
23C. PHYSICIAN'S NAME (Type) <u>Fredrich P. Smith MD</u>				23D. ADDRESS <u>University Hospital</u>							
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <u>1-31-68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Patuxent Church and</u>		24D. LOCATION (City, town, or county) (State) <u>Huntington, Cal. MD.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 5 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>Leroy E. Berry Huntington, MA</u>		25D. ADDRESS <u>Huntington, MA</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-500		68-- 1417		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68-- 1417	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) HELEN H. CONAWAY				2. DATE AND HOUR OF DEATH JAN. 31, 1968 2:06 AM.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 39 PROVIDENT HOSPITAL BALTIMORE, MD.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 16-05			
D. STREET ADDRESS (If rural, give location) 2330 MOSHER ST.							
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 9/9/12	9. AGE (In years last birthday) 55	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home nurse		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Blackwell				14. MOTHER'S MAIDEN NAME Fannie Hudnell			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 219-10-9956		17. INFORMANT ADDRESS George V. Conaway Same	
18. 410.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION 10 MINUTES				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) ARTERIOSCLEROTIC HEART DIS. UNKNOWN			
(C)							
420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				HYPERTENSIVE VASC. DIS. UNKNOWN			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/1 1967 to 1/31 1968 , that (I) (we) last saw the deceased alive on 1/31 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE D. W. Stewart M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/31/68	
23C. PHYSICIAN'S NAME (Type) D. W. STEWART M.D.				23D. ADDRESS 3414 DUVALL AV.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial 2-3-68		24B. DATE 2-3-68		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Ph. Baltimore MD.		24D. LOCATION (City, town, or county) (State) MD.	
25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Urlington Phillips		ADDRESS 1727 M. Monmouth St.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-1418

BIRTH NO. 67-24743

REG. NO.

1. NAME OF DECEASED (Type or Print) BOBBIE C. SPENCE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> February 3, 1968		Month Day Year February 3, 1968		Hour 9:30 A.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD February 3, 1968		Month Day Year February 3, 1968		Hour 9:30 A.	
6. SEX Male		7. RACE Negro		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Dec 12, 1967		10. AGE (In years lost birthday) 8 wks.		E. STREET AND NUMBER 1256 Kitmore Road		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTH PLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Robert L. Spence		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Rosalie Carnish		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT Rosalie Spence		ADDRESS Same	
19. 484 X I		CAUSE OF DEATH Interstitial Pneumonitis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION 1		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type): Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 2-4-68							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-5-68		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Pk.		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Arlington Phillips		ADDRESS 1727 N. Mount St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-1419</u>	
J-520 68-1419				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>James, Samuel C.</u>		2. DATE AND HOUR OF DEATH <u>February 2 - 68 6:45 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD MARYLAND</u> , CITY OF <u>BALTIMORE</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3904 Fendall Road 28-02</u>		
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-3-04</u>	9. AGE (In years last birthday) <u>63</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
13. FATHER'S NAME <u>JOHN JAMES</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA COOPER</u>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-10-9869</u>		17. INFORMANT <u>King W. James</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Gram Negative Sepsis</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of Head of Pancreas</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>157X II</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1-15-68</u> 19 to <u>2-2-68</u> 19, that (I) (we) last saw the deceased alive on <u>2-2-68</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>F. J. Scarpa, M.D.</u>				23B. DATE SIGNED <u>2-2-68</u>	
23C. PHYSICIAN'S NAME (Type) <u>FRANCIS J. SCARPA, M.D.</u>				23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>2-5-68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Ph. Bactinon</u>	
24D. LOCATION (City, town, or county) (State) <u>MD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>FEB 5 1968</u>		25B. NAME OF REGISTRAR <u>Urbington S. Phillips</u>	
25C. FUNERAL DIRECTOR <u>1727 N. Mount St.</u>		25D. ADDRESS			

2014 11/11/14

From negative 2422
To light to examine
Pencils

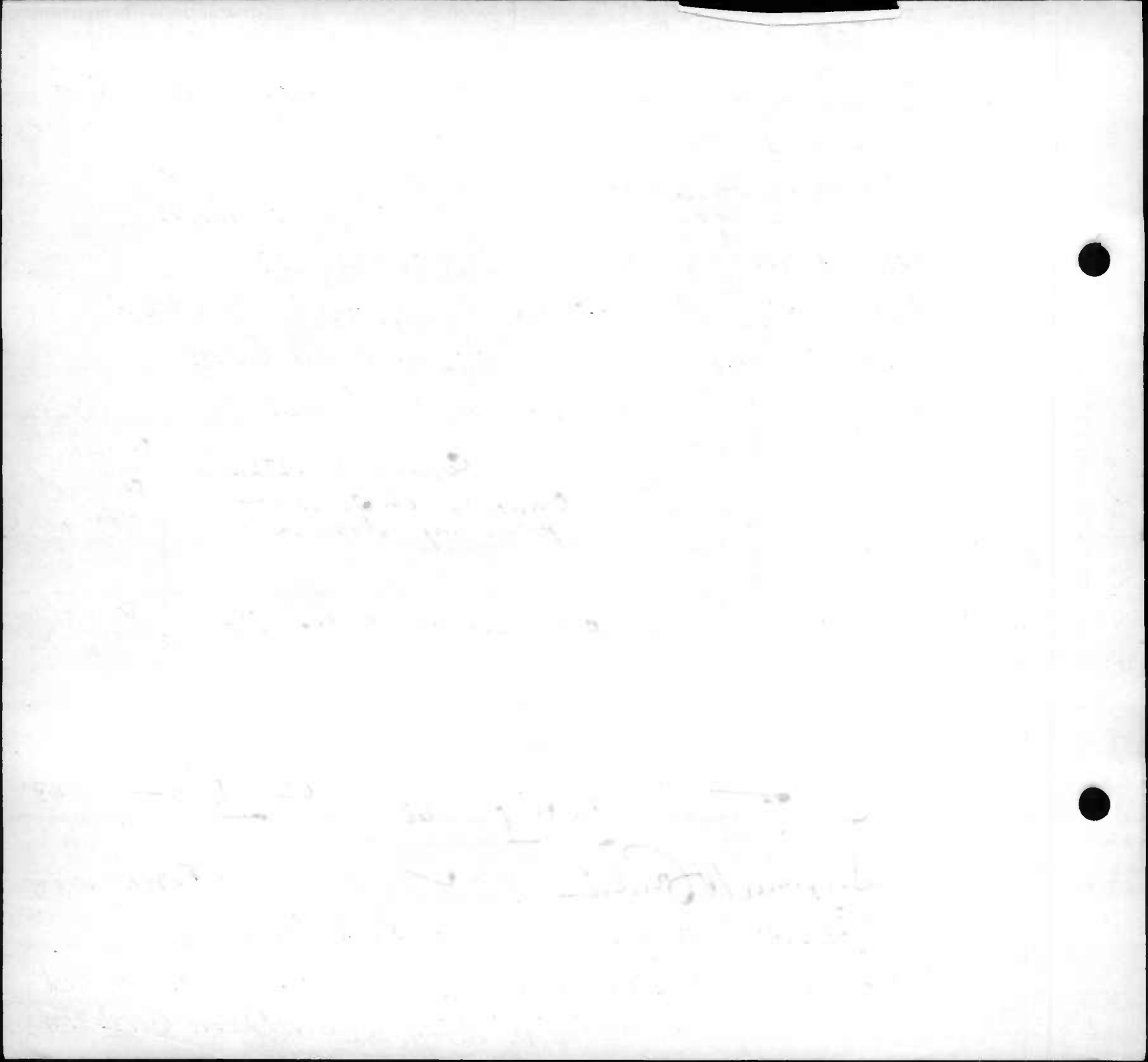
242

1/11/14

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1420	
H-655		68-1420		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		John Mahlon HARMON		February 2 1968 8 4 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
		A. STATE Md		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN	
5716 Highgate Drive				Baltimore	
		D. INSIDE CITY LIMITS?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER		5716 Highgate Drive	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Male	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Sept 28 1890	77	Postal Clerk
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Postal Service		Postal Service		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
James Harmon		Mary Ellen Cross		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		220303156A		Helen Benson	
18. CAUSE OF DEATH		ADDRESS			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Several minutes	
ANTECEDENT CAUSES		(B) CHRONIC OBSTRUCTIVE PULMONARY DISEASE -		Several years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Arteriosclerosis cardiovascular system		Several years	
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
6					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (the hospital) attended the deceased from 19 62 to Feb 2 19 68, that (I) (we) last saw the deceased alive on Feb 1 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Seymour H Rubin				Feb 5, 1968	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Seymour H Rubin		5415 Park Heights Ave			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	2-5-68	Druid Ridge	Pikesville Balt Co Md		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
FEB 5 1968		By 7		Burger Funeral Home Balt to Md	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1421

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 1421

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JULIE SILBERMANN

2. DATE AND HOUR OF DEATH

2/4/68

3.05 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)LEVINDALE HEBREW HOME &
INFIRMARY.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

Baltimore

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

Belverde & Greenspring Avenue

5. SEX

6. RACE

Female

W

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

Aug 2, 1894

9. AGE (In years
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.

Months

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Seamstress

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF WHAT COUNTRY?

U. S. / A.

13. FATHER'S NAME

Heineman

14. MOTHER'S MAIDEN NAME

Minna Goldberg

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

077-24-6541

17. INFORMANT

Mrs. Henry Silberman 3423 Washington Ave.
Baltimore, Md.

ADDRESS

18.

410.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

ACUTE MYOCARDIAL INFARCTION 30 MINS.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

ARTERIOSCLEROTIC HEART DISEASE

NOT KNOWN.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (H) (this hospital) attended the deceased from 9/23/1965 to 2/4/1968,
that (S) (we) last saw the deceased alive on 2/4/1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.

23A. SIGNATURE

George Beren, M.D.

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

2/4/68

23C. PHYSICIAN'S
NAME (Type)

GEORGE BEREN, M.D.

DEGREE

23D. ADDRESS

LEVINDALE HEBREW HOME & INFIRMARY

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

2-5-68.

24C. NAME OF CEMETERY OR CREMATORY

Zion
Shaarei Cemetery

24D. LOCATION

Rosedale

(City, town, or county)

Baltimore

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

FEB 5 1968

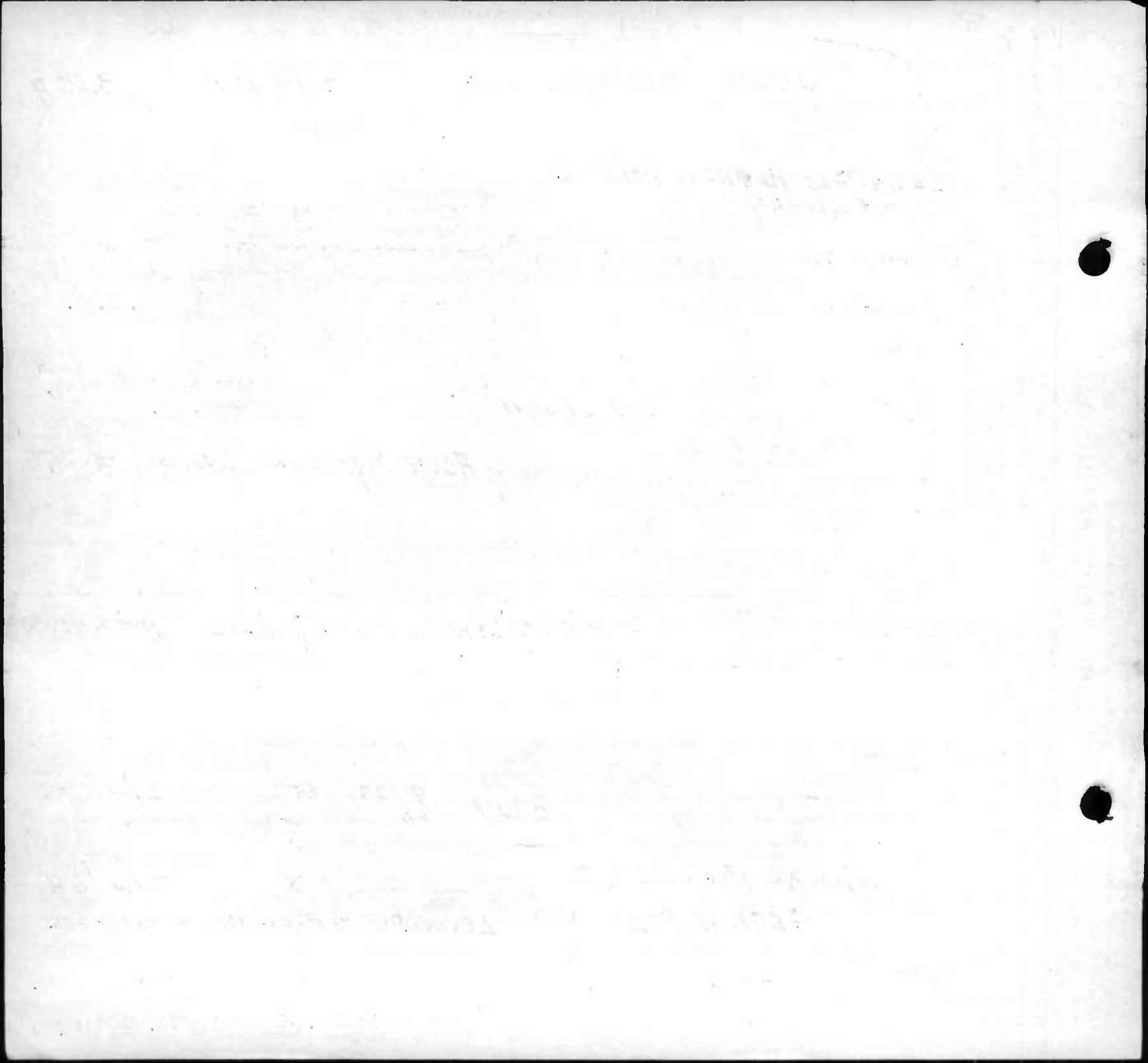
25B. NAME OF REGISTRAR

R. E. E. E. E.

25C. FUNERAL DIRECTOR

Jack Lewis Inc. 2100 Eutaw Pl. Baltimore, Md.

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

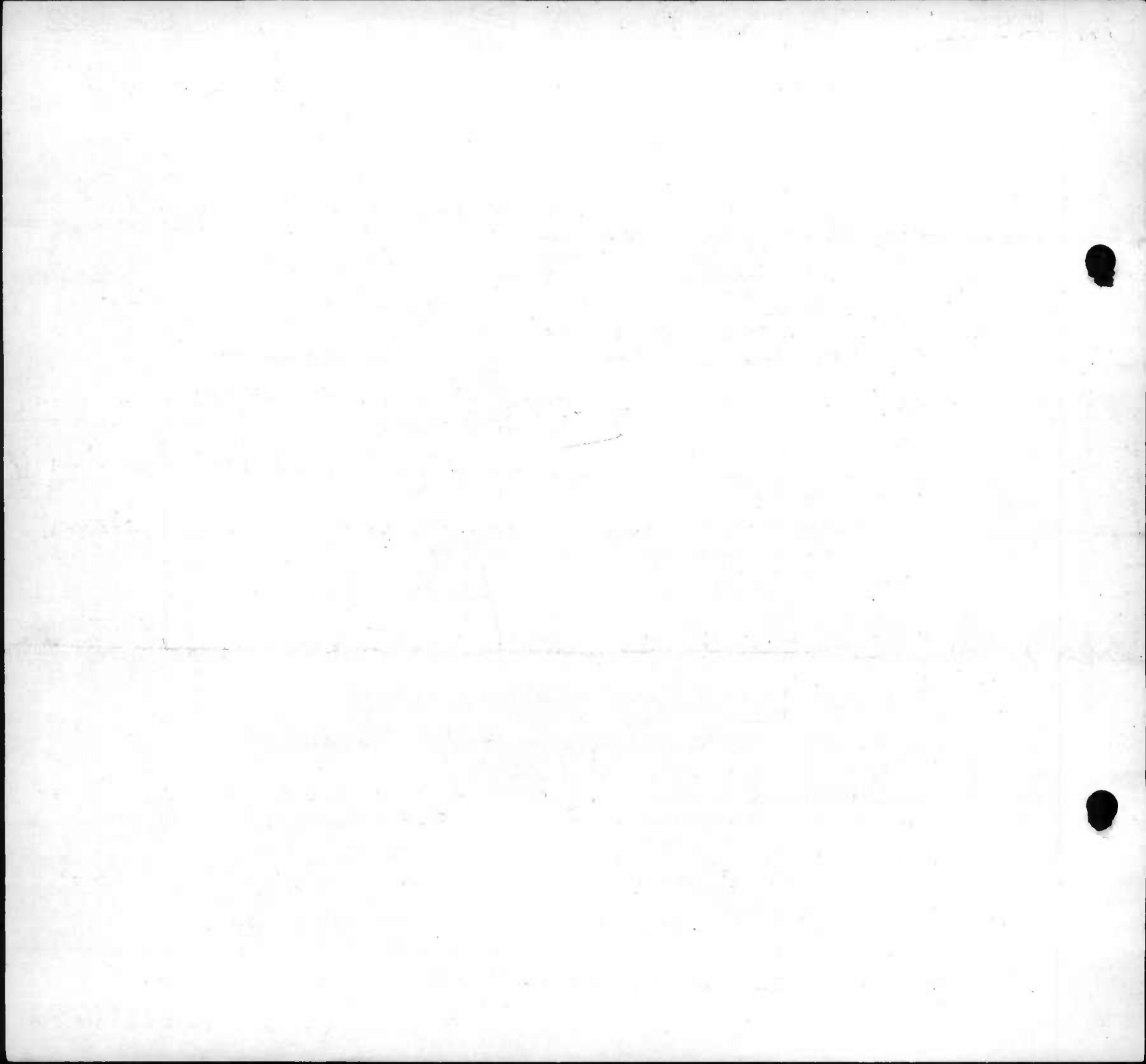
68- 1422

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 1422

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>MARY MASZCZYNSKA</i>		2. DATE AND HOUR OF DEATH <i>2-3-68 8⁴⁵ P</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>53-00</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Hq North Charles Hosp</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>1-4-98</i> 9. AGE (In years last birthday) <i>70</i>	
11. BIRTHPLACE (State or foreign country) <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>		13. FATHER'S NAME <i>WALTER WASOWSKA</i> <i>Anthony Maszczyński</i>	
14. MOTHER'S MAIDEN NAME <i>Amelia</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-36-7548</i>	
17. INFORMANT <i>Chart. N. CH. G. H. same</i>		ADDRESS		18. CAUSE OF DEATH I <i>410.9</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II <i>420.1</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>2-1</i> 19 <i>68</i> to <i>2-3</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>2-3</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Luis E Rengel</i>				23B. DATE SIGNED <i>2-3-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr. S Stern</i>				23D. ADDRESS <i>21206 Ridge Rd</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>FEB. 7, 68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Holy Rosary Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md. / #51237</i>		25A. DATE REC'D BY HEALTH DEPT. <i>FEB 5 1968</i>		25B. NAME OF REGISTRAR <i>Philip E. Crach</i>	
25C. FUNERAL DIRECTOR <i>1211 Chesaco Ave.</i>		ADDRESS			



E-520

68- 1423

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 1423

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

FREDRICK L. EMKEY SR

2. DATE AND HOUR OF DEATH

1 FEB' 68 6:20 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)UNIVERSITY of Md Hospital
LOMBARD & GREENE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD.

#37 BALTIMORE

C. CITY OR TOWN

ROSEDALE

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

1515 ROSEWICK AVE

5. SEX

M

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

10/9/1895 72

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

retired? Allied Chem. Co.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (state or foreign country)

BALTIMORE, MD US

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

PETER EMKEY

14. MOTHER'S MAIDEN NAME

ANNA VANKER

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

215-10-5361A

17. INFORMANT

ADDRESS

Wife

18.

162.1 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

BRONCHOGENIC CARCINOMA 1 yr.

MEDICAL CERTIFICATION

162.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

pneumonia

1 yr.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

NO

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

NO

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

NO

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from

2/1

19 68 to

2/1

19 68.

that (I) (we) last saw the deceased alive on

2/1

19 68 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

John W. Maun MD

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

2/1/68

23C. PHYSICIAN'S
NAME (Type)

John W. MAUN MD

23D. ADDRESS

UNIVERSITY HOSPITAL

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

2/5/68

24C. NAME OF CEMETERY or CREMATORY

MT. CARMEL

24D. LOCATION

(City, town, or county)

(State)

BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT.

FEB 5 1968

25B. NAME OF REGISTRAR

John E. Farkas

25C. FUNERAL DIRECTOR

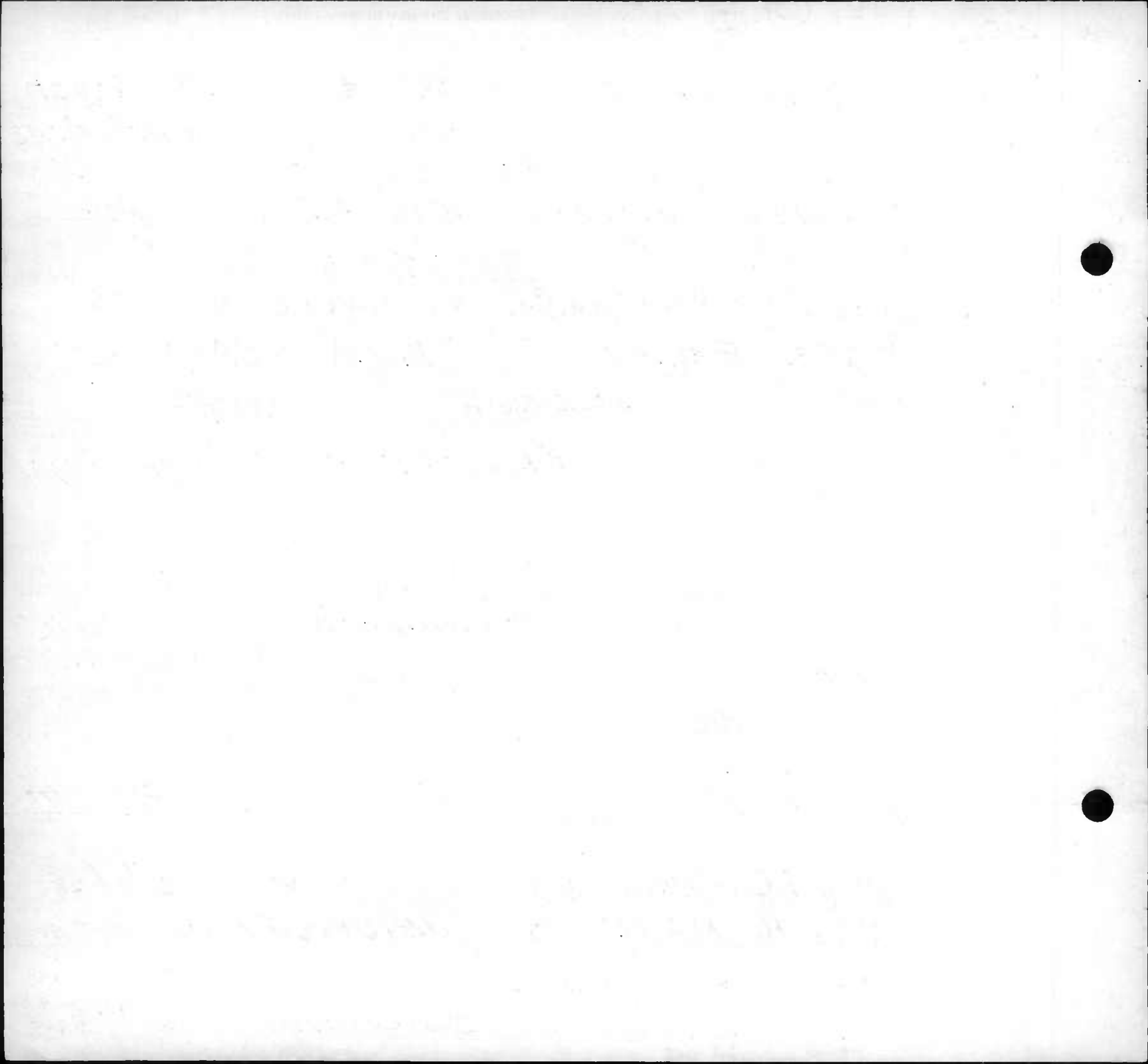
J.C. CONNELLY SONS

ADDRESS

300
MACE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

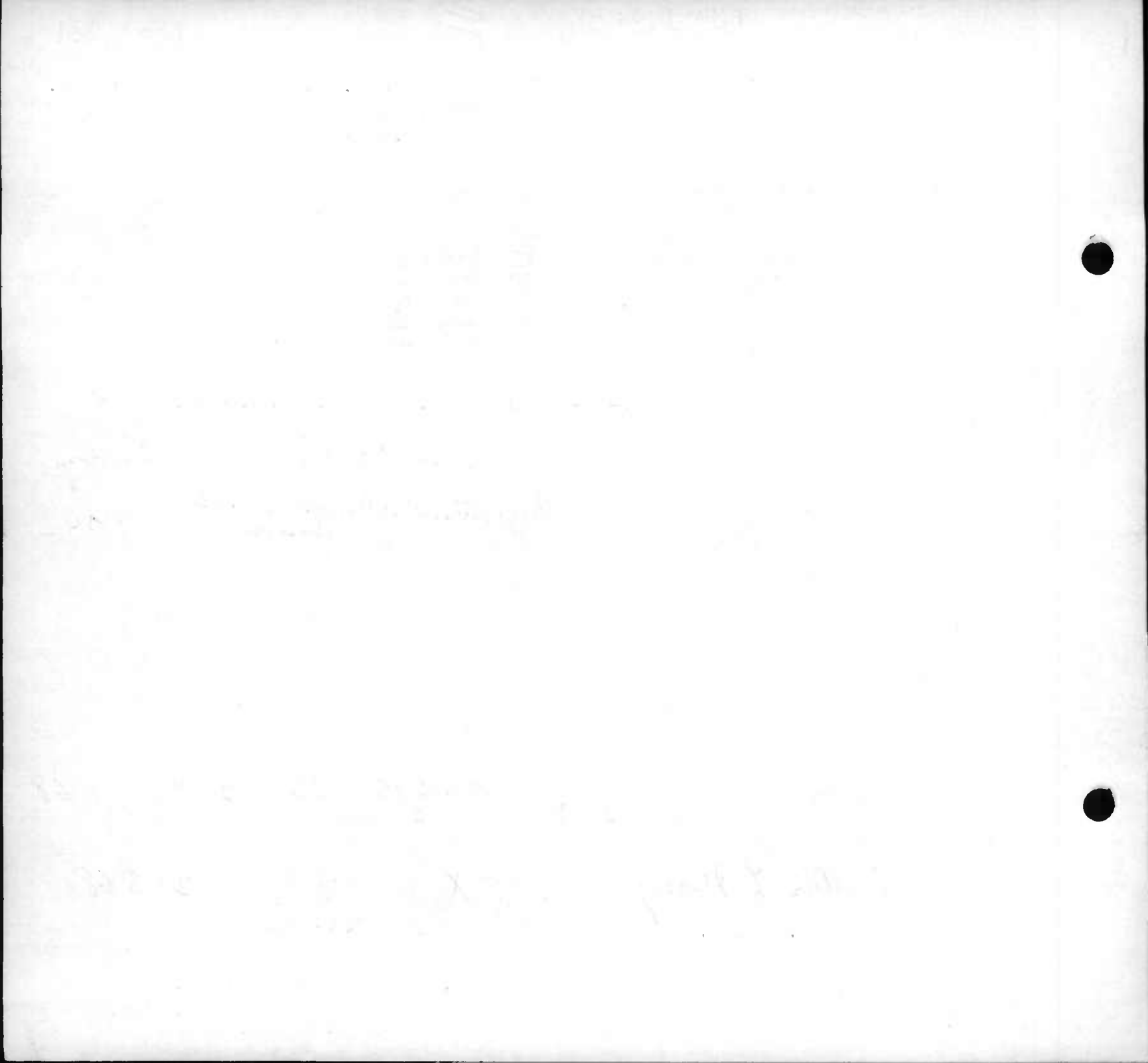
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1424

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-1424

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ANNA MARIE MITCHELL		2. DATE AND HOUR OF DEATH Feb. 3, 1968 10:30 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 60 4303 Clareway			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md., 21213 B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4303 Clareway		
5. SEX female	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/2/81	9. AGE (In years last birthday) 86	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Penna.	
13. FATHER'S NAME Englert			14. MOTHER'S MAIDEN NAME unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-54-3738J		17. INFORMANT Mrs. Edna M. King, dght, above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 412.0 I CAUSE OF DEATH Heart Exhaustion Hypertensive Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 443X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few days year		
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 15 1965 to 2-3 1968, that (I) (we) last saw the deceased alive on 2-3 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William L. Fearing				23B. DATE SIGNED 2-5-68	
23C. PHYSICIAN'S NAME (Type) Dr. Wm. L. Fearing		23D. ADDRESS 3025 Belair Road			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 2/6/68		24C. NAME of CEMETERY or CREMATORY Lorraine Park Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. FEB 6 1968			
25B. NAME OF REGISTRAR Charles E. Fearing		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 1425

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JO ANNE LYNN BAKER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour February 3, 1968 1:10 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 HOPKINS HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour February 3, 1968 1:10 A.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 26-03	
9. DATE OF BIRTH 12/21/60		10. AGE (In years lost birthday) 7	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Baker		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student	
15. MOTHER'S MAIDEN NAME Bernice Sorrell		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS William baker, father, above	
19. E 812.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Multiple Traumatic Injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Sinclair Lane and Moravia Road		22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) 2 23 1968 9:00 P	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Passenger in auto-auto collision	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2-3-68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/6/68	
24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		25B. NAME OF REGISTRAR Werner U. Spitz, M.D.	
25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 3331 Brehms Lane	

WALLACE BOYD

68-1426

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-1426

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Also Known as Lovetta) (Type or Print) LOVE MAE HARRIS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour February 3, 1968 6:00 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 002804 Kentucky Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour February 3, 1968 6:00 P.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-01	
9. DATE OF BIRTH 9/10/1878		10. AGE (In years lost birthday) 89	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Daniel E. Shaw		14. STREET AND NUMBER 2804 Kentucky Avenue	
15. MOTHER'S MAIDEN NAME Sarah Jane Rogers		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 212-07-8687D		18. INFORMANT Edith M. Miller, dght, above	
19. 412.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: [Signature] M.D. DATE SIGNED: 2-4-68 EXAMINER'S NAME (Type): Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/7/68	
24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		25B. NAME OF REGISTRAR [Signature]	
25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane			

Handwritten signature or initials.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 68-1427	
BIRTH NO. 68-1427		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Whiten, Ella		2. DATE AND HOUR OF DEATH Feb - 3 - 68 8.30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		5. STREET ADDRESS (If rural, give location) Rockland Road, Pikesville #8	
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 2-14-92	9. AGE (In years last birthday) 75	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY Private		11. BIRTHPLACE (State or foreign country) King & Queen Co., Va.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212 32 3508A		17. INFORMANT Charles E Whiten Rockland Ave 8	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Diabetic Acidosis		CAUSE OF DEATH Diabetic Acidosis		INTERVAL BETWEEN ONSET AND DEATH 5 days	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		20. SOCIAL SECURITY NO. 212 32 3508A		21. BIRTHPLACE (State or foreign country) King & Queen Co., Va.	
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fracture right hip (Intertrochanteric)		23. SOCIAL SECURITY NO. 212 32 3508A		24. BIRTHPLACE (State or foreign country) King & Queen Co., Va.	
19A. DATE OF OPERATION 1-11-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture of hip		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Rockland Road Pikesville #6	
21D. TIME OF INJURY (APPROX.) Jan. 8-68		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Accidental fall	
22. I certify that (I) (this hospital) attended the deceased from 2-1-1968 to 2-3-1968 , that (I) (we) last saw the deceased alive on 2-3-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Francis S. Saly		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 2-3-68	
23C. PHYSICIAN'S NAME (Type) Francis S. Saly		23D. ADDRESS Sinai Hospital H. O		23E. FUNERAL DIRECTOR Lewis T Gwynn 2707 Ruscombe La. (15)	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Feb. 7, 1968		24C. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery	
24D. LOCATION (City, town, or county) (State) Randallstown, Maryland		25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		25B. NAME OF REGISTRAR Robert E. Fairman	

1912

1912



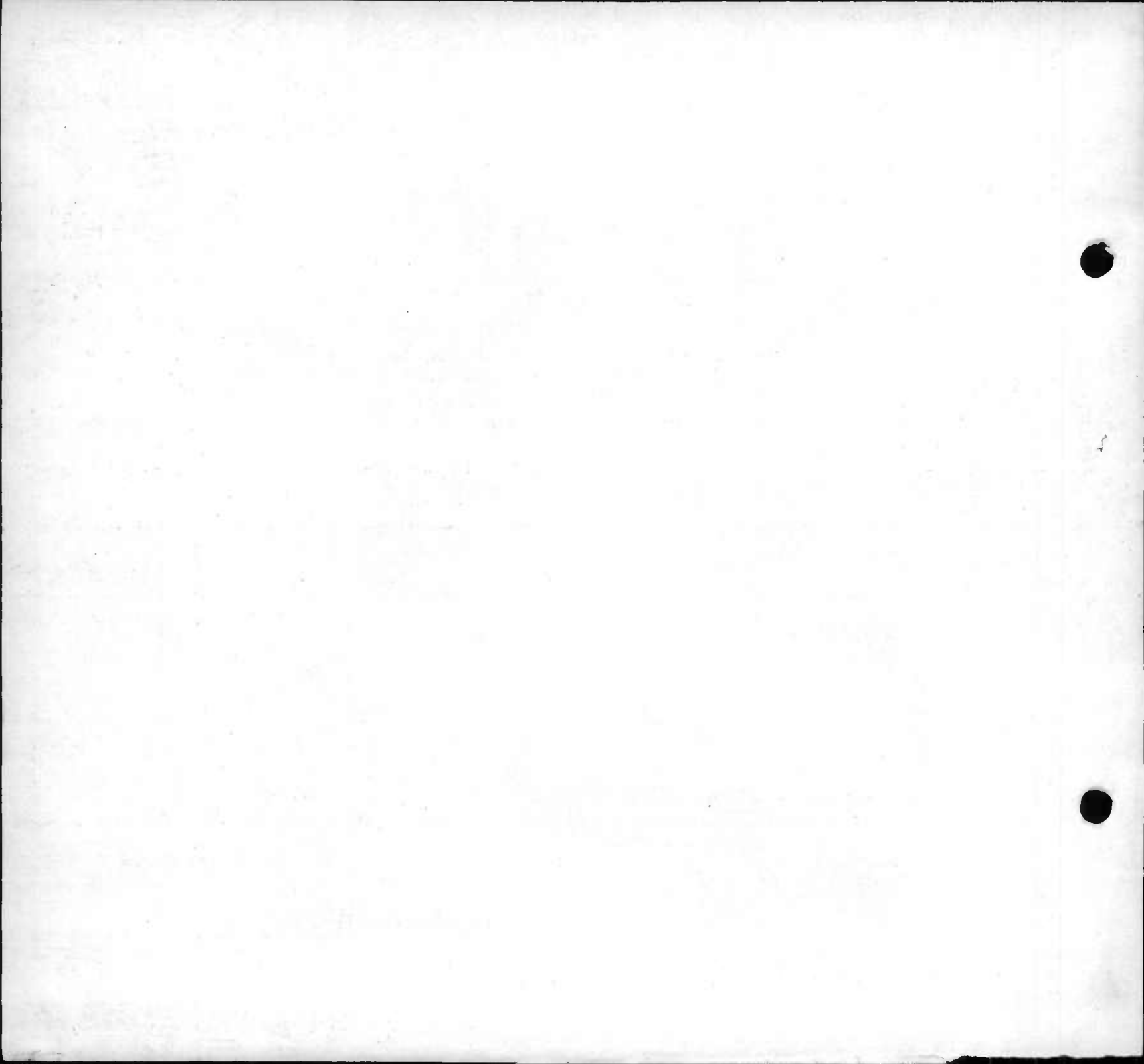
1912

1912

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
REG. NO. 68-1428									
7-400		68-1428		CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) JAMES R. PAUL, JR.				2. DATE AND HOUR OF DEATH 2/3/68 9 ¹⁵ P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY Anne Arundel Co.				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 8 UNIVERSITY HOSPITAL					C. CITY OR TOWN ANNAPOLIS		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
					E. STREET AND NUMBER 2 OAK COURT		52-10		
5. SEX MALE	6. RACE CAUC.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/22/35	9. AGE (In years last birthday) 32	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nursing Supervisor				10B. KIND OF BUSINESS OR INDUSTRY State Hospital		11. BIRTHPLACE (State or foreign country) TENN.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JAMES R. PAUL, SR.				14. MOTHER'S MAIDEN NAME ROSE N. FORD					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Janet Sue Paul #4		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 250.9 I UREMIA + CHRONIC RENAL FAILURE DIABETIC NEPHROPATHY					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: UREMIA + CHRONIC RENAL FAILURE DIABETIC NEPHROPATHY 3 YRS.				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO, OR AS A CONSEQUENCE OF: CONGESTIVE HEART FAILURE 6 MOS.				
					(C) DIABETES MELLITUS 14 YRS.				
260X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). DIABETIC NEUROPATHY									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 1/30 1968 to TIME OF DEATH 1968, that (I) (we) lost saw the deceased alive on 2/3 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Marcia C. Schmitt M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 2/3/68		
23C. PHYSICIAN'S NAME (Type) Marcia C. Schmitt					23D. ADDRESS UNIVERSITY HOSPITAL, BALTO. MD.				
24A. BURIAL CREMATION, REMOVAL (Specify) Transit-Burial		24B. DATE 2-8-68		24C. NAME OF CEMETERY OR CREMATORY Richmond Cemetery		24D. LOCATION (City, town, or county) Ewing,		(State) Va.	
25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		25B. NAME OF REGISTRAR Robert E. Jackson, M.D.			25C. FUNERAL DIRECTOR John H. Taylor + Sons Annapolis, Md.			ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1429

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-1429

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

STREETS, SARAH

2. DATE AND HOUR OF DEATH

2/14/68 9:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Bolton Hill Nursing & Convalescent Ctr.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland Balto Co.

C. CITY OR TOWN

Halethron

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

1960 Belle Avenue

5. SEX

F

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

8/22/00

9. AGE (In years
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

House work

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

James Galloway

14. MOTHER'S MAIDEN NAME

Catherine Watson

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218-12-23317

17. INFORMANT

Evelyn Willis 1960 Belle Ave

ADDRESS

18.

342X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Paroxysmal disease with
paralysis of arms, legs, etc.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

arteriosclerosis generalized

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

4952 on
gradually getting
worse.

MEDICAL CERTIFICATION

350X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9/28 1967 to 2/4 1968.
that (I) (we) lost saw the deceased alive on 2/4 1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

W. Marshall

Attending
Phys. ☒

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

2/14/68

23C. PHYSICIAN'S
NAME (Type)

23D. ADDRESS

2 E. Paul St Balto Md 11008

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

2/14/68

24C. NAME OF CEMETERY or CREMATORY

Meadowridge Cemetery

24D. LOCATION

(City, town, or county)

(State)

Dorsey, Maryland

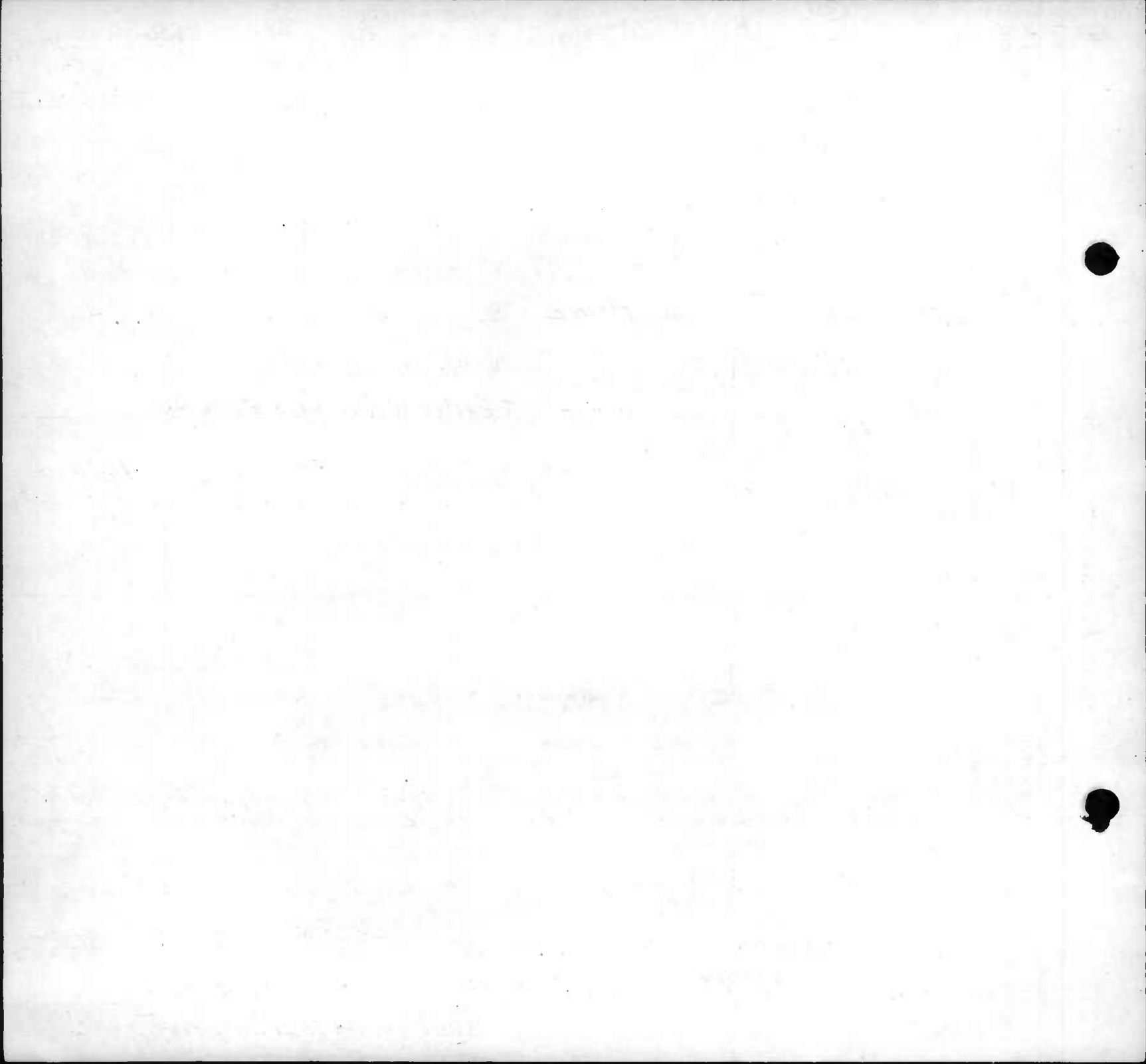
25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Amber 700 1328 Sulphur Sp. Rd



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1430

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

REG. NO.

6872 1430

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MORAN, MICHAEL James

2. DATE AND HOUR OF DEATH

2/3/68 3:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Bolton Hill Nursing & Convalescent Ctr.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN D. INSIDE CITY LIMITS?

Baltimore YES ☐ NO ☐

E. STREET AND NUMBER

1222 Pine Heights Avenue

5. SEX 6. RACE 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH 9. AGE (In years last birthday) If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME

XXXXXXXXXXXX John Moran XXXXXXXXXXXX Mary Anna Grimes

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

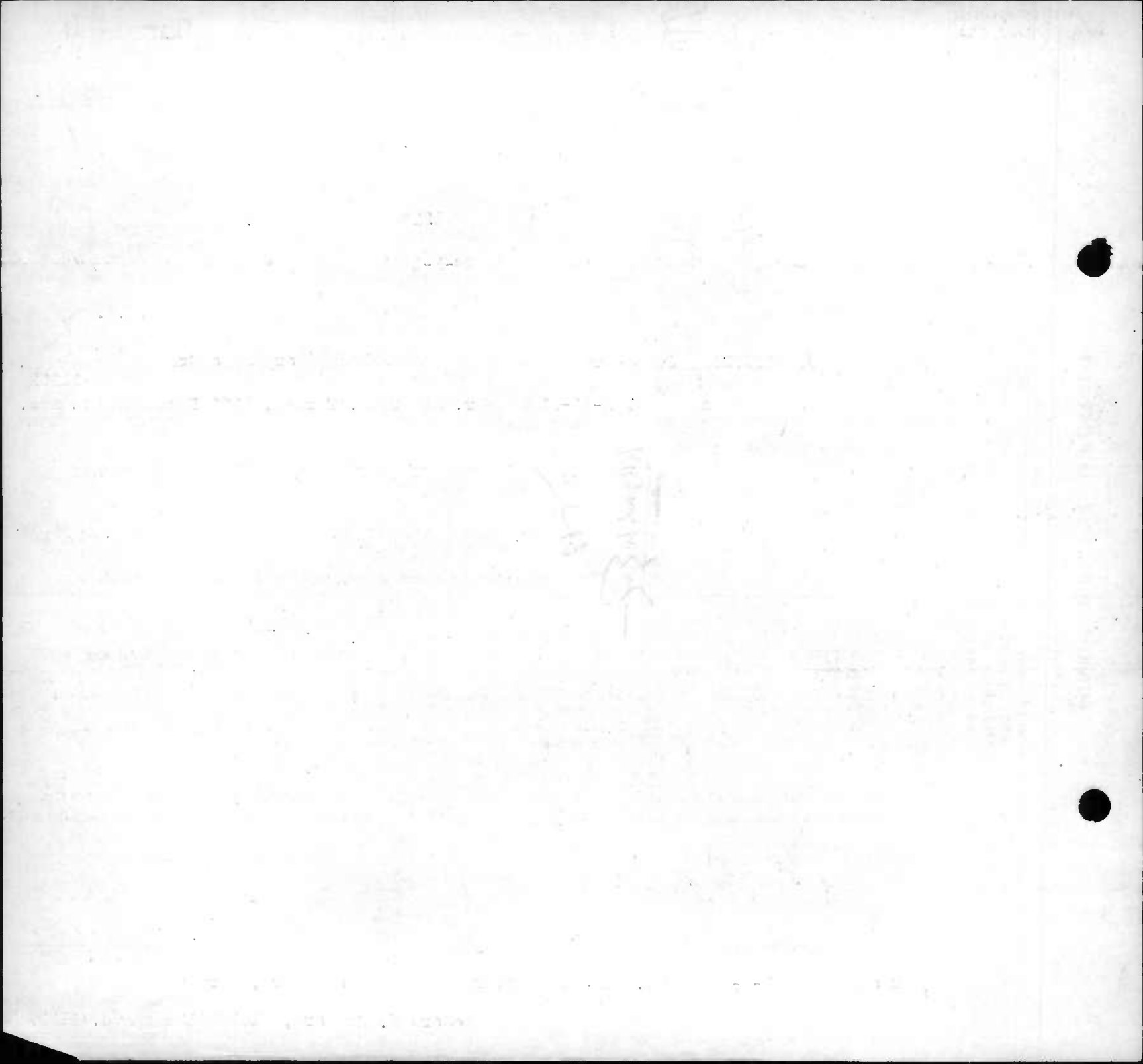
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS



FUNERAL DIRECTOR: IMPORTANT

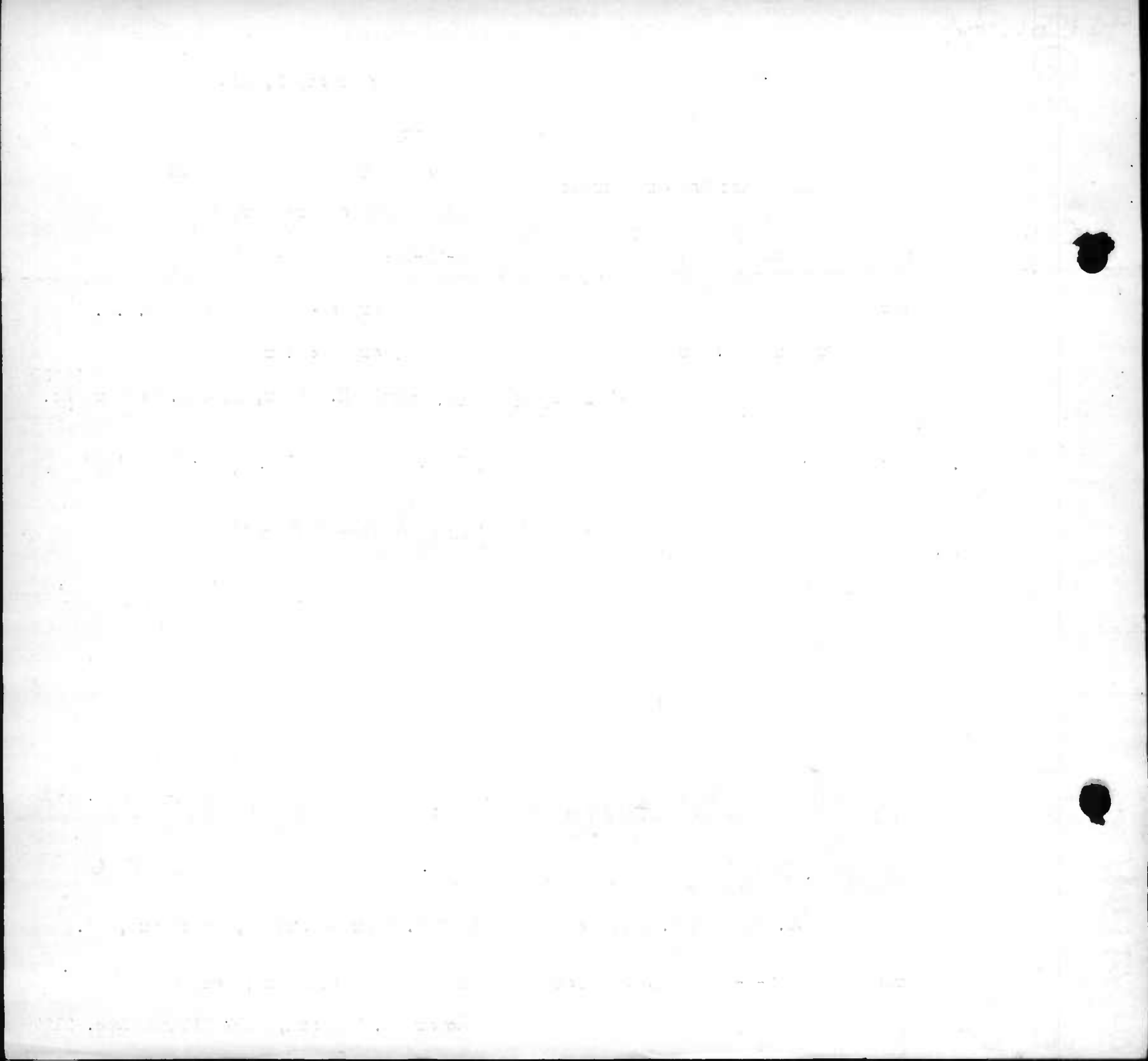
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1431

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 1431

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		GABEL BAUER		February 3, 1968 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1144 West Hamburg Street				A. STATE Maryland	
				B. COUNTY	
				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1144 West Hamburg Street	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-27-1898	9. AGE (In years last birthday) 69
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Frederick Bauer	
14. MOTHER'S MAIDEN NAME Mary Walters				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 216-10-7985				17. INFORMANT Mrs. Myrtle I. Bauer, 1144 W. Hamburg St.	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Due to, or as a consequence of: <i>Carcinoma of lungs c7</i>	
				(B) <i>Metastasis to brain + liver</i> Due to, or as a consequence of:	
				(C) _____	
19. DATE OF OPERATION				20. AUTOPSY? (Yes or No) NO	
21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
23. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
24. TIME OF INJURY (Month) (Day) (Year) (Hour)				25. HOW DID INJURY OCCUR?	
26. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
27. I certify that (I) (this hospital) attended the deceased from <i>Feb-23</i> 19 <i>67</i> to <i>Feb-3</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>FEB 3</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
28. SIGNATURE <i>Vincent M. Messina M.D.</i>				29. DATE SIGNED <i>2-5-68</i>	
30. PHYSICIAN'S NAME (Type) Dr. Vincent M. Messina				31. ADDRESS 1403 S. Charles Street, Baltimore, Md.	
32. BURIAL CREMATION, REMOVAL (Specify) Burial		33. DATE 2-6-68		34. LOCATION (City, town, or county) (State) Baltimore, Maryland	
35. DATE REC'D BY HEALTH DEPT. FEB 5 1968		36. NAME OF REGISTRAR <i>Robert E. Jackson</i>		37. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1432

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68-1432

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Plowden Elizabeth Margie

2. DATE AND HOUR OF DEATH

2-2-68 1:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD.

SAINT MARY'S

C. CITY OR TOWN

MECHANICSVILLE

D. INSIDE CITY LIMITS?

YES ☐

NO ☐

E. STREET AND NUMBER

SAMSONS FARM

5. SEX

Female

6. RACE

Negro

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

9-22-19

9. AGE (In years last birthday)

48

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

SAMUEL EDWARDS

14. MOTHER'S MAIDEN NAME

ANNIE BARNES

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

CHARLES H. PLOWDEN MECHANICSVILLE, MARYLAND

18.

5-60.21

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Pneumonia

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Illness -> abdominal distention

5 days

(C) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Chronic renal pseudogout of joints -> 2-3 months

MEDICAL CERTIFICATION

570.3 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

1-29-68

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

Chronic - cancer

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-10-68 to 2-2-68, that (I) (we) last saw the deceased alive on 2-2-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Antonio Gonzalez

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

2-2-68

23C. PHYSICIAN'S NAME (Type)

Antonio Gonzalez

DEGREE

23D. ADDRESS

Johns Hopkins Hosp Baltimore

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

2/6/68

24C. NAME OF CEMETERY or CREMATORY

ST. JOHNS CEMETERY

24D. LOCATION

HOLLYWOOD, ST. MARY'S, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

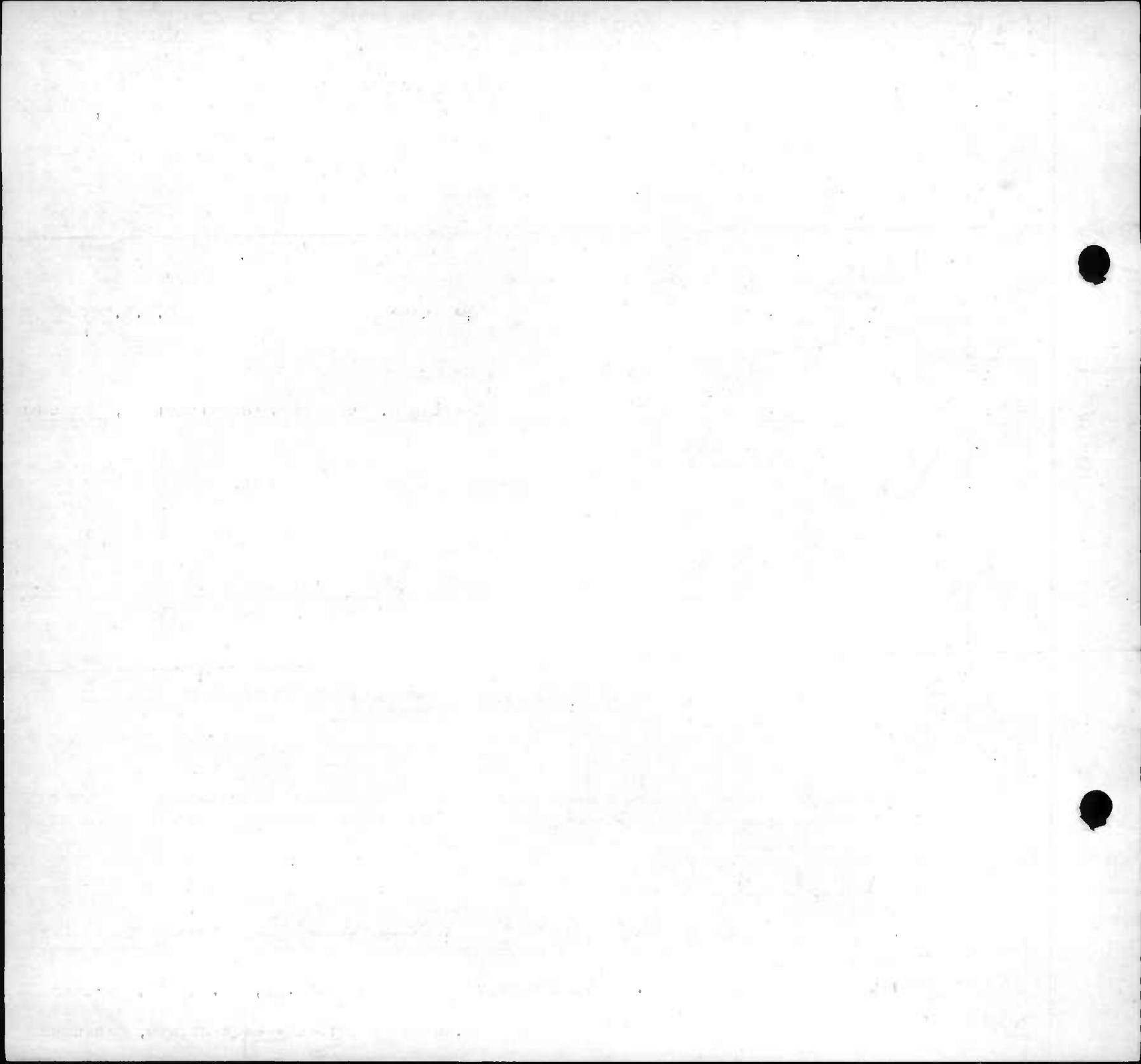
FEB 5 1968

25B. NAME OF REGISTRAR

Robert E. Johnson

25C. FUNERAL DIRECTOR

W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1433

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 1433

BIRTH NO.		1. NAME OF DECEASED (Type or Print) NELSON J. EWING <i>James Nelson Ewing</i>		2. DATE AND HOUR OF DEATH Feb 3 1968 11:20 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 44 The Union Memorial Hosp.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 9-07		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 06-11-07		9. AGE (In years lost birthday) 60		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper cutter	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218 09 1451	
17. INFORMANT Margaret R. Ewing		18. CAUSE OF DEATH 712.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 722.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? respiratory insufficiency 1 year pneumonia fibrosis 1 year rheumatoid arthritis 2 years acute bronchopn, confluent mof		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 02-02-68 19 to 02-03-68 1968, that (I) (we) last saw the deceased alive on 02-03-68 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Joe T. Chandler</i> DEGREE		23B. DATE SIGNED 02-03-68		23C. PHYSICIAN'S NAME (Type) DR. JOE T. CHANDLER <i>Joe T. Chandler</i> DEGREE	
23D. ADDRESS THE UNION MEMORIAL HOSPITAL <i>The Union Memorial Hosp.</i>		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 2-7-1968		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Co. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Feb 5 1968 R. E. Taylor		25C. FUNERAL DIRECTOR Lassahn Funeral Home 4401 Belair Rd.	

12/27/2019 - 12/28/2019

✱

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1434

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 1434

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Adeline B. Burns

2. DATE AND HOUR OF DEATH

2-2-68

2:52 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland Baltimore

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Baltimore

YES ☐

NO ☒

E. STREET AND NUMBER

8736 Cimarron Circle #21234

5. SEX

Female

6. RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

11-13-08

9. AGE (In years last birthday)

59

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

AT HOME

11. BIRTHPLACE (State or foreign country)

BALTIMORE Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry L.B. Mangels

14. MOTHER'S MAIDEN NAME

ANNA C. Maurer

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

213-05-5490

17. INFORMANT

ADDRESS

Patient on Admission

18.

412.9 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

?

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-30-68 to 2-2-68, that (I) (we) last saw the deceased alive on 2-2-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

William L. Rodde M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

2-2-68

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

Maryland General Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

BURIAL

2-6-68

OAK LAWN CEM.

7225 EASTERN BLVD. BALTO. CO., MD.

25A. DATE REC'D BY HEALTH DEPT.

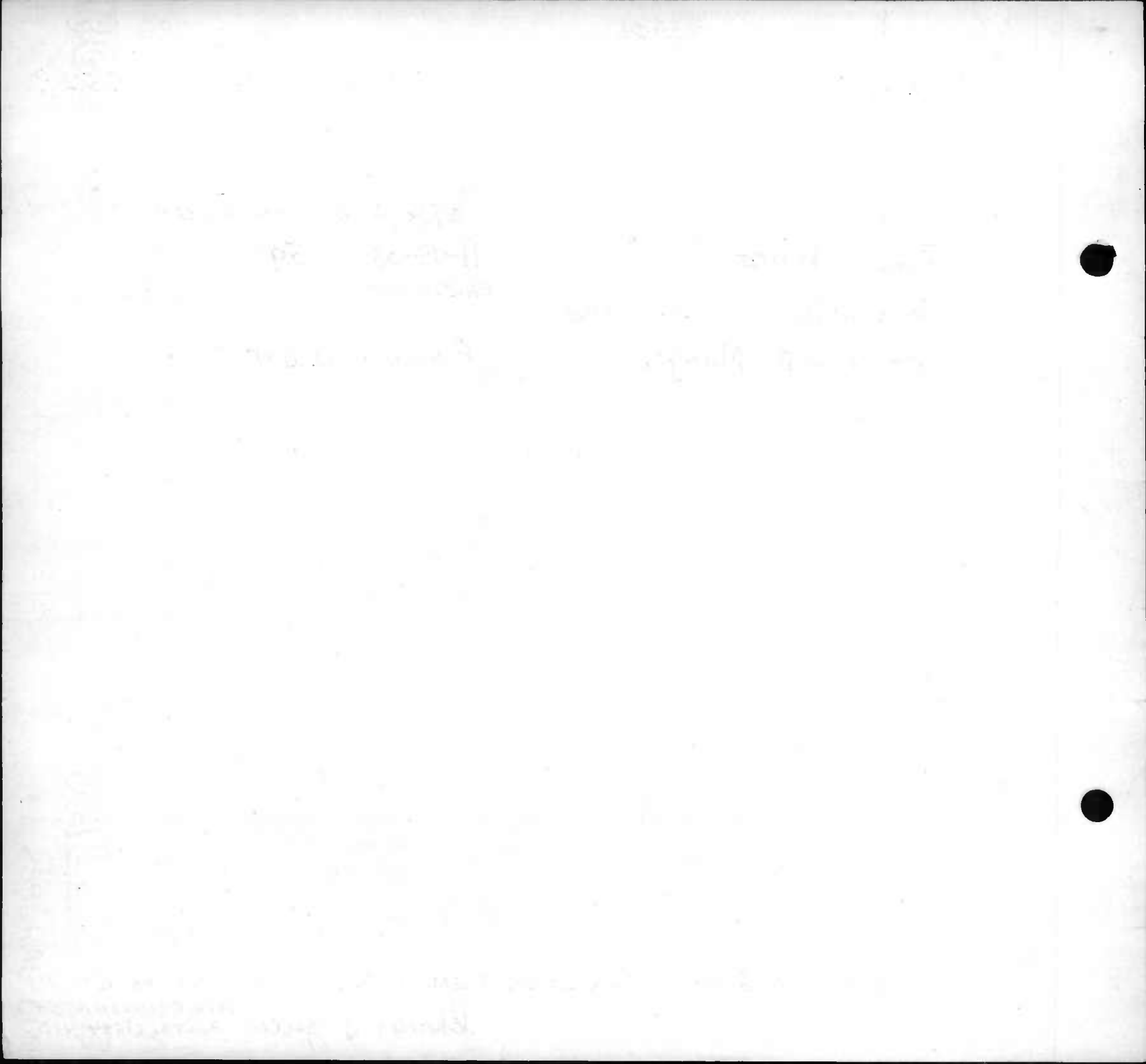
25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

FEB 5 1968 Robert E. Fisher

Charles S. Zeiler 9015 CONKLING ST. BALTO., 21224, MD.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1435	
68-1435				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Charles WERNER Weiss		2. DATE AND HOUR OF DEATH Feb. 3, 1968 6:45 PM.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 43 South Baltimore General Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Harford Co.		6.2-00	
FULL NAME OF HOSPITAL OR INSTITUTION 43		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN (Rocks) Jarrettsville	
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER Rigdon Rd.			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 17, 1892	9. AGE (In years last birthday) 75	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Owner		10B. KIND OF BUSINESS OR INDUSTRY Grocery		11. BIRTHPLACE (State or foreign country) Md. (Baltimore)	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Carl Weiss		14. MOTHER'S MAIDEN NAME Anna WERNER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-05-8719		17. INFORMANT (See) 692-2726 Mr. Charles C. Weiss ADDRESS Rigdon Road - Box # 141 Jarrettsville, Maryland 21084	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute myocardial infarction 3 days (B) ASCVD Disease (C) Uremia			
19A. DATE OF OPERATION 420.1 II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-1-68 19 to 2-3-68 19, that (I) (we) last saw the deceased alive on 2-3-68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. Carter, M.D.				23B. DATE SIGNED 2-3-68	
23C. PHYSICIAN'S NAME (Type) Colvin C. Carter				23D. ADDRESS So. Balto. General Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Feb. 6, 1968		24C. NAME OF CEMETERY or CREMATORY Bel Air Memorial Gardens	
24D. LOCATION (City, town, or county) (State) Bel Air, Harford Co., Maryland 21014		25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968			
25B. NAME OF REGISTRAR Robert E. Fink		25C. FUNERAL DIRECTOR Joseph William Foster ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014			

South Eastern General Hospital

X

W

M

Rippon Rd.

Col. 17, 1893

12

(Lambert)

Md.

1893

(1893-1894)

1893-1894

1893-1894

1893-1894

1893-1894

1893-1894

1893-1894

Col. 17, 1893

Col. 17, 1893

Col. 17, 1893

✓

1893-1894

1893-1894

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1436	
BIRTH NO. 252 68-1436				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ABRAHAM PAUL LOSINSKY			2. DATE AND HOUR OF DEATH 2-3-1968 4:20 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) FRANKLIN SQUARE HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1 N. BENTALOU ST.		
5. SEX Male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-17-1908 72	9. AGE (In years last birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETAIL MERCHANT		10B. KIND OF BUSINESS OR INDUSTRY RETAIL		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME SOLOMON LOSINSKY			14. MOTHER'S MAIDEN NAME XXXXXXXXXX SOPHIE BERLIN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W I ARMY		16. SOCIAL SECURITY NO. 216-32-9738		17. INFORMANT ADDRESS MRS. ROSE LOSINSKY, 1 N. BENTALOU ST. #21223	
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 163X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 2-3-1968 to 2-3-1968 , that (I) (we) last saw the deceased alive on 2-3-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. 23A. SIGNATURE J. LEE, M.D. 23B. DATE SIGNED 2-3-68 23C. PHYSICIAN'S NAME (Type) J. LEE, M.D. 23D. ADDRESS FRANKLIN SQUARE HOSPITAL 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 24B. DATE 2-5-68 24C. NAME OF CEMETERY or CREMATORY BETH EL MEMORIAL PARK 24D. LOCATION (City, town, or county) (State) RANDALLSTOWN, MD. 25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968 25B. NAME OF REGISTRAR P. E. Taylor 25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD					

Handwritten text, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher but appears to include words like "Handwritten", "written", and "written".



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

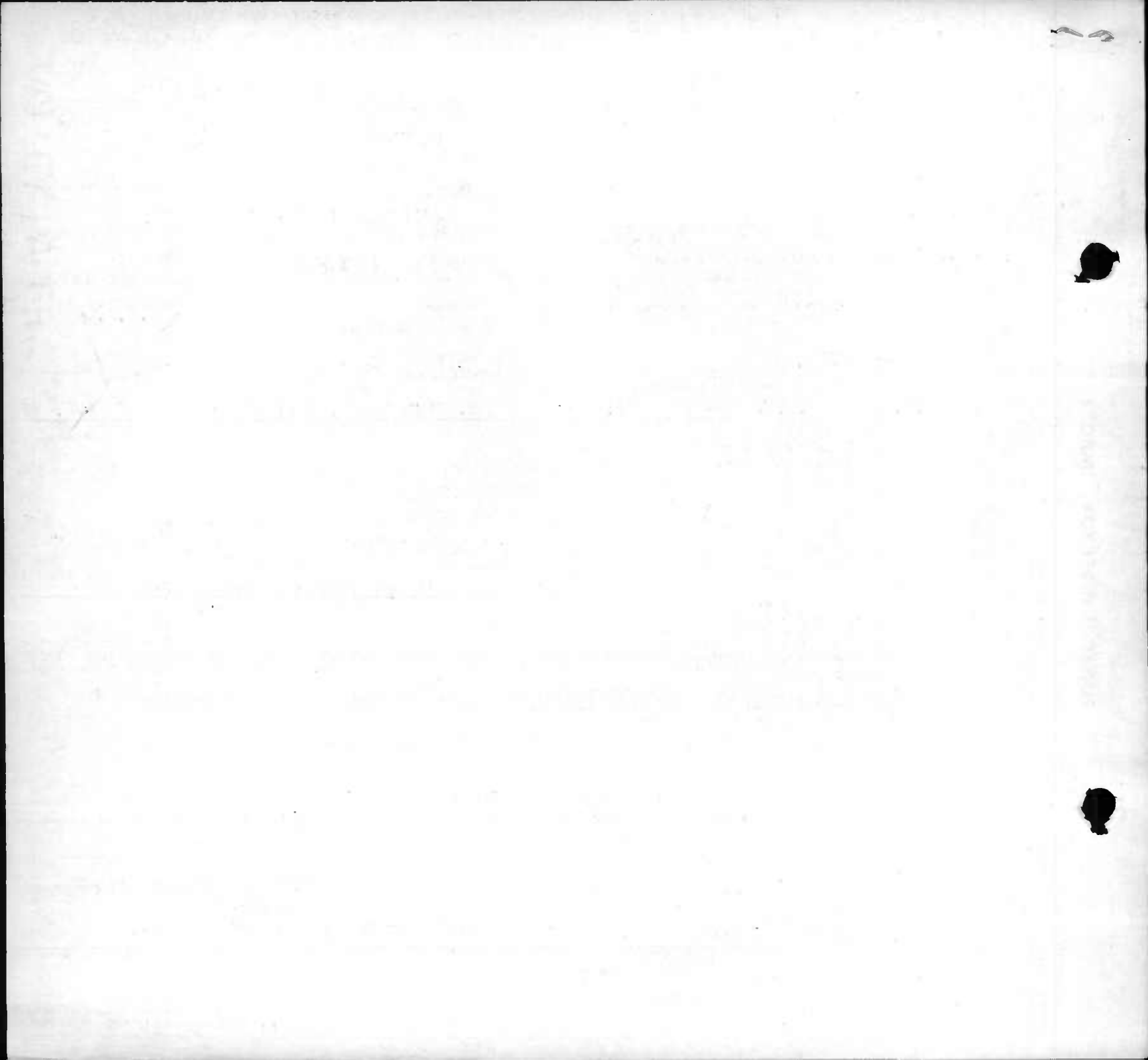
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1437
BIRTH NO. 1. NAME OF DECEASED (Type or Print) JOSEPH FRIEDMAN		2. DATE AND HOUR OF DEATH Feb 2, 1968 2:05 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2713 OSWEGO AVENUE		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 15-13 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2713 OSWEGO AVENUE		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 20, 1895	9. AGE (In years last birthday) 72
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR		10B. KIND OF BUSINESS OR INDUSTRY SHOP		11. BIRTHPLACE (State or foreign country) RUSSIA
13. FATHER'S NAME WOLF FRIEDMAN		14. MOTHER'S MAIDEN NAME ANNA ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-05-0127A		17. INFORMANT MRS. KATIE FRIEDMAN ADDRESS 2713 OSWEGO AVE., #21215
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 410.9 + 1 250.9 </div> <div style="width: 50%;"> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarction </div> </div> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II </div> <div style="width: 50%;"> (B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Cardio Vascular Disease </div> </div> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes Mellitus </div> <div style="width: 50%;"> (C) DUE TO, OR AS A CONSEQUENCE OF: Diabetes Mellitus </div> </div>				
MEDICAL CERTIFICATION <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> 19A. DATE OF OPERATION 0 </div> <div style="width: 45%;"> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED II </div> </div> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> 20A. AUTOPSY? (Yes or No) No </div> <div style="width: 50%;"> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No </div> </div> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> </div> <div style="width: 50%;"> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None </div> </div> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None </div> <div style="width: 50%;"> 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) None </div> </div> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> </div> <div style="width: 50%;"> 21F. HOW DID INJURY OCCUR? None </div> </div>				
22. I certify that (I) (this hospital) attended the deceased from 1953 to Feb 2 1968 that (I) (we) last saw the deceased alive on Feb 1 1968 and that in (my) (our) opinion death occurred on the date Feb 2 1968 and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE [Signature]			23B. DATE SIGNED Feb 2, 1968	
23C. PHYSICIAN'S NAME (Type) SAMUEL V. TOMPAKOV, M.D.			23D. ADDRESS 3600 Park Heights Ave. Baltimore, Md 21215	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 2-4-68		24C. NAME OF CEMETERY or CREMATORY OHEL YAKOV
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968 25B. NAME OF REGISTRAR [Signature] 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD ADDRESS		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. C-500				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1438	
1. NAME OF DECEASED (Type or Print) PHILLIP COHEN				2. DATE AND HOUR OF DEATH FEB. 1, 1968 @ 8:15 PM. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL OF BALTIMORE 42				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4011 LIBERTY HEIGHTS AVENUE			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 1888 80		9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROPRIETOR		10B. KIND OF BUSINESS OR INDUSTRY QUEEN CITY WINDOW CLEANING		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MYER COHEN				14. MOTHER'S MAIDEN NAME MEITE ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) XXXXYES W.W. I		16. SOCIAL SECURITY NO. 219-32-2230		17. INFORMANT ADDRESS MRS. ROSE COHEN, 4011 LIBERTY HEIGHTS AVE. #7			
18. 250.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 260X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION NONE 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				CAUSE OF DEATH (A) IMMEDIATE CAUSE ACID-BASE ELECTROLYTE DUE TO, OR AS A CONSEQUENCE OF: IMBALANCE (B) OF BOTH DIABETIC ACIDOSIS CELLULITIS & GANGRENE LOWER EXTREMITY, EMPHYSEMA YEARS (C) CNS ARTERIOSCLEROSIS + INSUFFICIENCY, CORONARY ARTERY DISEASE, GEN. ARTERIO SCLEROSIS, SEVERAL YRS			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from Feb 1 1968 to Feb 1 1968, that (1) (we) last saw the deceased alive on FEB 1 8:14 PM 19 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Eulogio O. Bonsukan MD DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED FEB 1, 1968	
23C. PHYSICIAN'S NAME (Type) EULOGIO O. BONSIKAN, MD DEGREE				23D. ADDRESS SINAI HOSPITAL OF BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 2-4-68		24C. NAME OF CEMETERY OR CREMATORY SHAAREI TFILOH		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1439	
4-345 68-1439				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Hitlin Fay -</u>		2. DATE AND HOUR OF DEATH <u>2-2-68</u> <u>8:45 P</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>12-02</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital</u>		E. STREET AND NUMBER <u>3501 St. Paul St</u>		APT. <u>318</u>	
5. SEX <u>FEMALE</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-16-04</u>	9. AGE (In years last birthday) <u>63</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>XXXXXX NEW YORK</u>	
13. FATHER'S NAME <u>LOUIS M. POZNANSKY</u>		14. MOTHER'S MAIDEN NAME <u>CHARNA MARKOWITZ</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MR. HARRY HITLIN</u>	
18. <u>394.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac Arrest -</u> (B) <u>Arterial D. blood press - Mitral Stenosis -</u> (C) <u>Rheumatic Heart Disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years -</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>410X II</u>		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1-20</u> 19 <u>68</u> to <u>2-2</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2-2</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>SAM LeBauer M.D.</u>				23B. DATE SIGNED <u>2-2-68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Sam LeBauer</u>				23D. ADDRESS <u>Sinai Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
<u>REMOVAL-BURIAL</u>		<u>2-4-68</u>		<u>MONTEFIORE</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 5 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN RD.</u>	

Given to the ...
...
...

...
...
...

...
...
...

...
...
...

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 1440

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

~~RUBIN~~

REUBEN

RAPORT

2. DATE OF DEATH

Known ☐

Month

Day

Year

Hour

Estimated ☐

February 2, 1968

6:20 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

SINAI HOSPITAL (DOA)

3. DATE PRONOUNCED DEAD

Month

Day

Year

Hour

February 2, 1968

6:20 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

6. SEX

Male

7. RACE

White

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☒

9. DATE OF BIRTH

Oct 11, 1905

10. AGE (In years lost birthday)

62

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

3402 Vargas Circle

11. BIRTHPLACE (State or foreign country)

Atlantic City N.J.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Morris Raport

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Attorney

14B. KIND OF BUSINESS OR INDUSTRY

Law

15. MOTHER'S MAIDEN NAME

Sarah Freiden

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

217-01-6482

18. INFORMANT

ADDRESS

Mrs. Bella Raport-3402 Vargas Circle

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Werner J. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

2-3-68

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

2/4/68

24C. NAME of CEMETERY or CREMATORY

Chizuk Amuno Cong.

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

FEB 5 1968

25B. NAME OF REGISTRAR

Robert E. Farley

25C. FUNERAL DIRECTOR

ADDRESS

SOL LEVINSON & BROS INC. 6010 Reist Rd.



Handwritten signature or initials

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1441

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 1441

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARY E. BAKER

2. DATE AND HOUR OF DEATH

2-4-68

11 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

MERCY HOSPITAL
301 ST. PAUL ST.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

MD

BALTIMORE Co

53-00

C. CITY OR TOWN
BALTIMORE

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

1066 E. DONNINGTON CIRCLE

5. SEX

F

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

9. AGE (In years
last birthday)

5/2/95

72

If Under 1 Yr.
Months: Days:

If Under 24 Hrs.
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

WILLIAM SHELLEY

14. MOTHER'S MAIDEN NAME

MARY TUTTLE

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

NONE

17. INFORMANT

ADDRESS

MEDICAL RECORDS

18. 436.9 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

UREMIA - TOXEMIA

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) URINARY TRACT INFECTION

DUE TO, OR AS A CONSEQUENCE OF:

(C) STROKE - CEREBRAL

VASCULAR ACCIDENT

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

7 days

18 days

20 days

MEDICAL CERTIFICATION

331X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

ASCVD

YEARS

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan. 15 1968 to Feb. 4 1968,
that (I) (we) lost saw the deceased alive on Feb. 4 1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

David S. McHold MD

Attending
Phys. ☐

Med.
Director ☐

Staff
Phys. ☒

23B. DATE SIGNED

2/5/68

23C. PHYSICIAN'S
NAME (Type)

DAVID STANLEY McHold MD

23D. ADDRESS

Mary Hop.

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

2-8-68

24C. NAME OF CEMETERY or CREMATORY

NEW CATHEDRAL CEMETERY

24D. LOCATION

(City, town, or county)

BALTIMORE, MD.

(State)

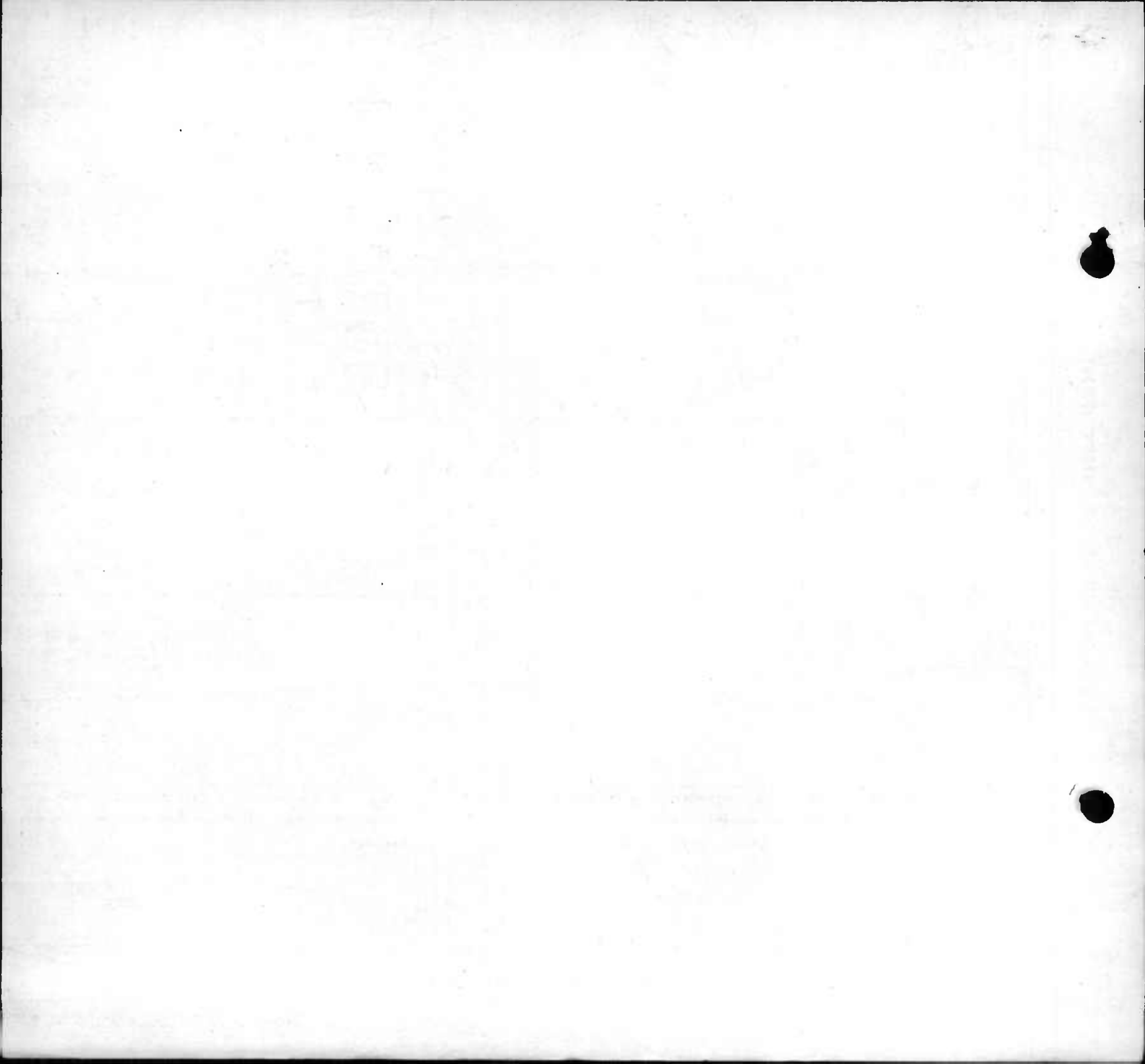
25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Wm. Cook-Brooks TOWSON 1050 YORK RD. 21204



68-1442

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-1442

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LAURA RUHWADEL		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour February 4, 1968 4:40 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3101 Normount Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour February 4, 1968 4:40 P.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 16-07			
6. SEX female	7. RACE white	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 2-21-1875	10. AGE (In years last birthday) 92	E. STREET AND NUMBER 3101 Normount Avenue	
11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Thomas		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
14B. KIND OF BUSINESS OR INDUSTRY Home		15. MOTHER'S MAIDEN NAME Liza ??	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 212-07-0849	
18. INFORMANT Roland G. Ruhwadel		ADDRESS (Same)	
19. CAUSE OF DEATH 412.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 422.11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2/5/68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-7-1968	
24C. NAME of CEMETERY or CREMATORY Woodlawn Cem.		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		25B. NAME OF REGISTRAR Robert E. ...	
25C. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc.		ADDRESS 1217 St. Paul St. Balto., Md. 21202	

THE
UNITED STATES
DEPARTMENT OF
THE ARMY
OFFICE OF THE
CHIEF OF STAFF
WASHINGTON, D. C.
20315

MAILING ORDER
FORM 100-10
MAY 1962 EDITION
GSA GEN. REG. NO. 27
5010-108-01

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1443

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

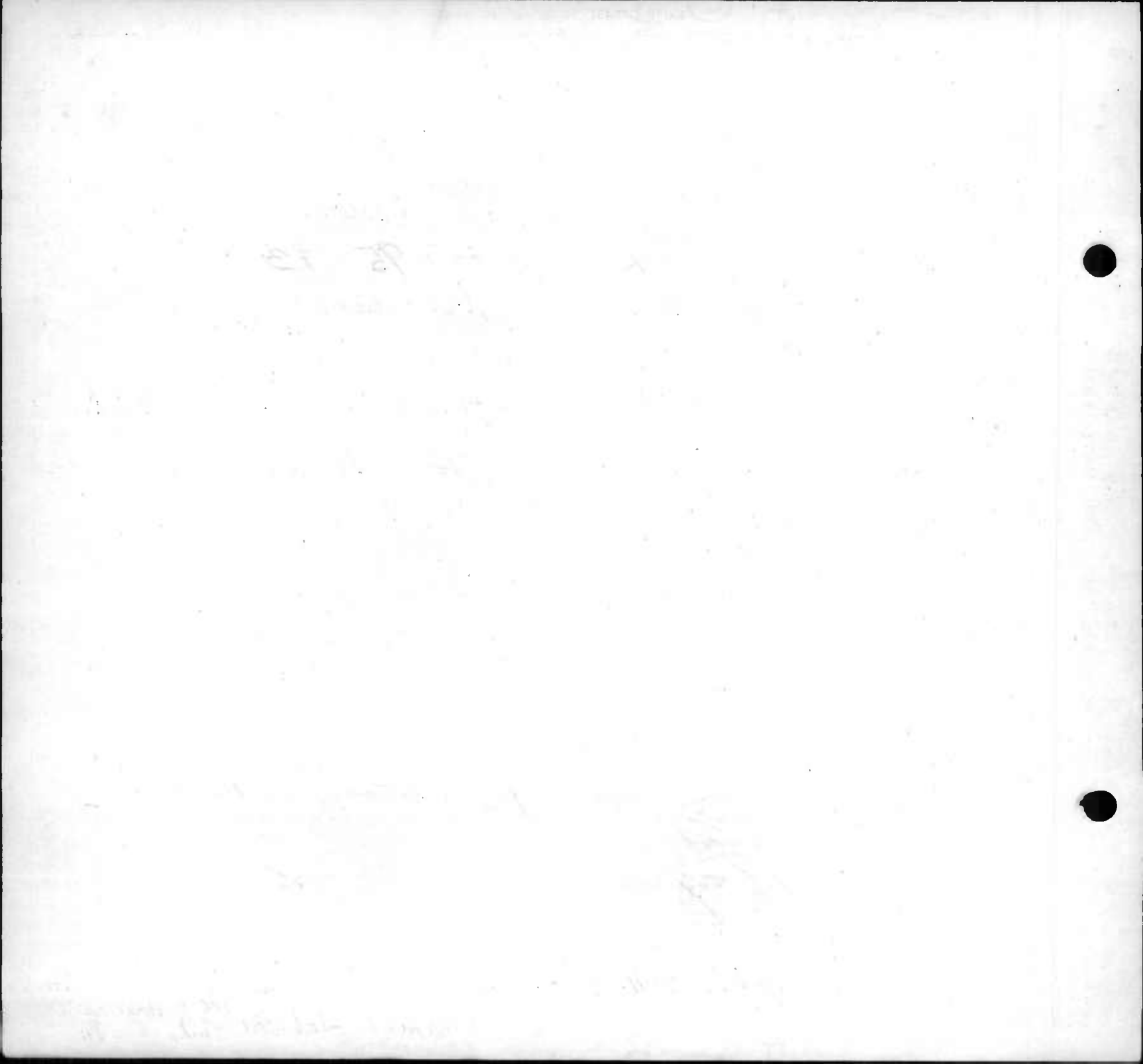
REG. NO. 68- 1443

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Clifford, Mary (Mrs.)</i>		2. DATE AND HOUR OF DEATH <i>2/4/68 5:25 A.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Balt. City</i>		C. CITY OR TOWN <i>Balt.</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>44 Union Memorial Hosp</i>		E. STREET AND NUMBER <i>116 W. Univ. Parkway</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-19-1885</i>	9. AGE (In years, last birthday) <i>72</i>	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Balto., Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Christopher F. Rochlitz</i>		14. MOTHER'S MAIDEN NAME <i>Rosalie F. Masek</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Thomas N. Clifford, 611 Park Ave</i> <i>SON 600 Rock Park Ave</i>	
18. <i>492 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Aspiration pneumonia</i> <i>Emphysema of lungs</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>MOX</i> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. DATE OF OPERATION <i>3-27-1</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>II</i>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1/31</i> <i>1968</i> to <i>2/4</i> <i>1968</i> , that (I) (we) last saw the deceased alive on <i>2/4</i> <i>1968</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>DR Barry J Weckesser</i>		23B. DATE SIGNED <i>2/4/68</i>		23C. PHYSICIAN'S NAME (Typed) <i>DR BARRY J WECKESSER</i>	
23D. ADDRESS <i>THE UNION MEMORIAL HOSP.</i>		23E. DEGREE <i>MD</i>		23F. ADDRESS <i>Wm. Cook-Brooks, Inc., 1217 St. Paul St., Balto.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>2-7-1968</i>		24C. NAME OF CEMETERY or CREMATORY <i>Most Holy Redeemer</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto., Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>FEB 5 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Fink</i>	
25C. FUNERAL DIRECTOR		25D. ADDRESS		25E. ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-1444</u>
<u>T-65C</u>		<u>68-1444</u>		CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>EUGENE TURNER</u>		
2. DATE AND HOUR OF DEATH <u>2.1.68</u>		<u>7:15 a.m.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Guthrie Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>28-04</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Guthrie Hospital</u>		C. CITY OR TOWN <u>Baltimore 21224</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>M</u>		6. RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>6-9-95</u>		9. AGE (In years last birthday) <u>73</u>		10. UNDER 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>RET</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>UN</u>		
14. MOTHER'S MAIDEN NAME <u>UN</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Agnis Cooper</u>		
18. <u>412.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>A SHCVD</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>2 hours</u>		
19. DATE OF OPERATION		20. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>1.2.68 Jan 19</u> to <u>1.2.68 Jan 19</u> , that (I) (we) last saw the deceased alive on <u>1.2.68</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>E. Rafel</u>		23B. DATE SIGNED <u>1.2.68</u>		23C. PHYSICIAN'S NAME (Type) <u>E. RAFEL</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>2/6/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Rolling Green</u>
24D. LOCATION (City, town, or county) (State) <u>Westchester PA</u>		25A. DATE REC'D BY HEALTH DEPT. <u>FEB 5 1968</u>		
25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>EMMAUEL Johnson Phil.</u>		
25D. ADDRESS <u>100 E. HORTON ST. PA</u>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-346		68-1445		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-1445	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print) GERTRUDE MAY STAYLOR				2. DATE AND HOUR OF DEATH 2-3-68 10:45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 FRANKLIN SQUARE HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1417 W. COMBARD			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-9-1887		9. AGE (In years last birthday) 80	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GARRETT TERPENING				14. MOTHER'S MAIDEN NAME GERTHA PROLICH			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 148-20-351		17. INFORMANT Charles E. Rice, Jr., 7715 Ruxwood Rd. Towson, Md. 21204		ADDRESS	
18. 4-10-9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). CUA				CAUSE OF DEATH MYOCARDIAL INFARCTION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1-30-1968 to 2-3-1968, that (I) (we) last saw the deceased alive on 2-3-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ruben V. Lunk MD				23B. DATE SIGNED 2-3-68			
23C. PHYSICIAN'S NAME (Type) RUBEN V. LUNK MD				23D. ADDRESS FRANKLIN SQUARE HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-7-68		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) Balto. (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		25B. NAME OF REGISTRAR Robert E. Taylor, MD		25C. FUNERAL DIRECTOR 4101 Edmondson Avenue, Baltimore, Md. 21229			

REPORT OF THE BOARD OF DIRECTORS

1917-1918

1918

THE BOARD OF DIRECTORS

OF THE COMPANY

FOR THE YEAR

ENDING DECEMBER 31, 1918

1918

1917-1918

THE BOARD OF DIRECTORS

OF THE COMPANY

1918

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
68- 1446					REG. NO. 68- 1446					
BIRTH NO.					2. DATE AND HOUR OF DEATH					
1. NAME OF DECEASED (Type or Print) MARY BAYLOR					2/2/68 9:12 P M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY					
33 THE JOHNS HOPKINS HOSPITAL					MARYLAND					
					C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
					BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
					E. STREET AND NUMBER					
					833 N. CAROLINE ST.					
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		
FEMALE		NEGRO		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6-13-16		51		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY					
Housewife					Honored County Va.					
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
Ollie Wiley					LAURA Robinson					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT			
							William Baylor-Meharickville			
18. 412.0 I					CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
(This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.)					CVA					
ANTECEDENT CAUSES					(B) DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					Hypertensive Cardiovas. Disease 3 yrs					
					(C) Hypertensive 10 yrs					
18. 443X II										
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
0						No				
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?				
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 2/2 1968 to 2/2 1968, that (I) (we) last saw the deceased alive on 2/2 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE								23B. DATE SIGNED		
Henry R. Black MD								2/2/68		
23C. PHYSICIAN'S NAME (Type)								23D. ADDRESS		
HENRY R. BLACK MD								Johns Hopkins Hosp.		
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE			24C. NAME OF CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)	
Removal Feb 6/68			FEB 5 1968			Robert E. Taylor, MD			Richmond Va.	
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR			ADDRESS	
FEB 5 1968			Robert E. Taylor, MD			Bryant E. Eubank 11297 Carlin St				

AND

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M.E. CASE NO.		68- 1447		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 68- 1447	
1. NAME OF DECEASED (Type or Print) <div style="text-align: center;">Charles Henry Shepperson</div>				2. DATE AND HOUR OF DEATH January 31, 1968 3 30 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <div style="text-align: center;">46 Lutheran Hospital</div>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) Baltimore 1729 Poplar Grove Street			
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH July 31, 1914	9. AGE (In years last birthday) 53	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10B. KIND OF BUSINESS OR INDUSTRY Edgewood Arsenal		11. BIRTHPLACE (State or foreign country) Charlotte Court House, Va		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Charles Henry Shepperson				14. MOTHER'S MAIDEN NAME Sarah Brown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW-II		16. SOCIAL SECURITY NO. 217-07-4368		17. INFORMANT ADDRESS Mrs. Lena C. Shepperson 1729 Poplar Grove St			
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Coronary Occlusion DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
MEDICAL CERTIFICATION 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 1st 1968 to Jan 31st 1968 , that (I) (we) last saw the deceased alive on Jan 31 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Paul M. Byerly				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 2/2/68	
23C. PHYSICIAN'S NAME (Type) Paul M. Byerly		23D. ADDRESS M.D. 5820 York Road Balto 21212 md					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 2/5/68	24C. NAME of CEMETERY or CREMATORY Balto. National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore CO. MD.			
25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		25B. NAME OF REGISTRAR R. E. E. Jones		25C. FUNERAL DIRECTOR ADDRESS Herbert E. Nutter 3035 W. North Ave			

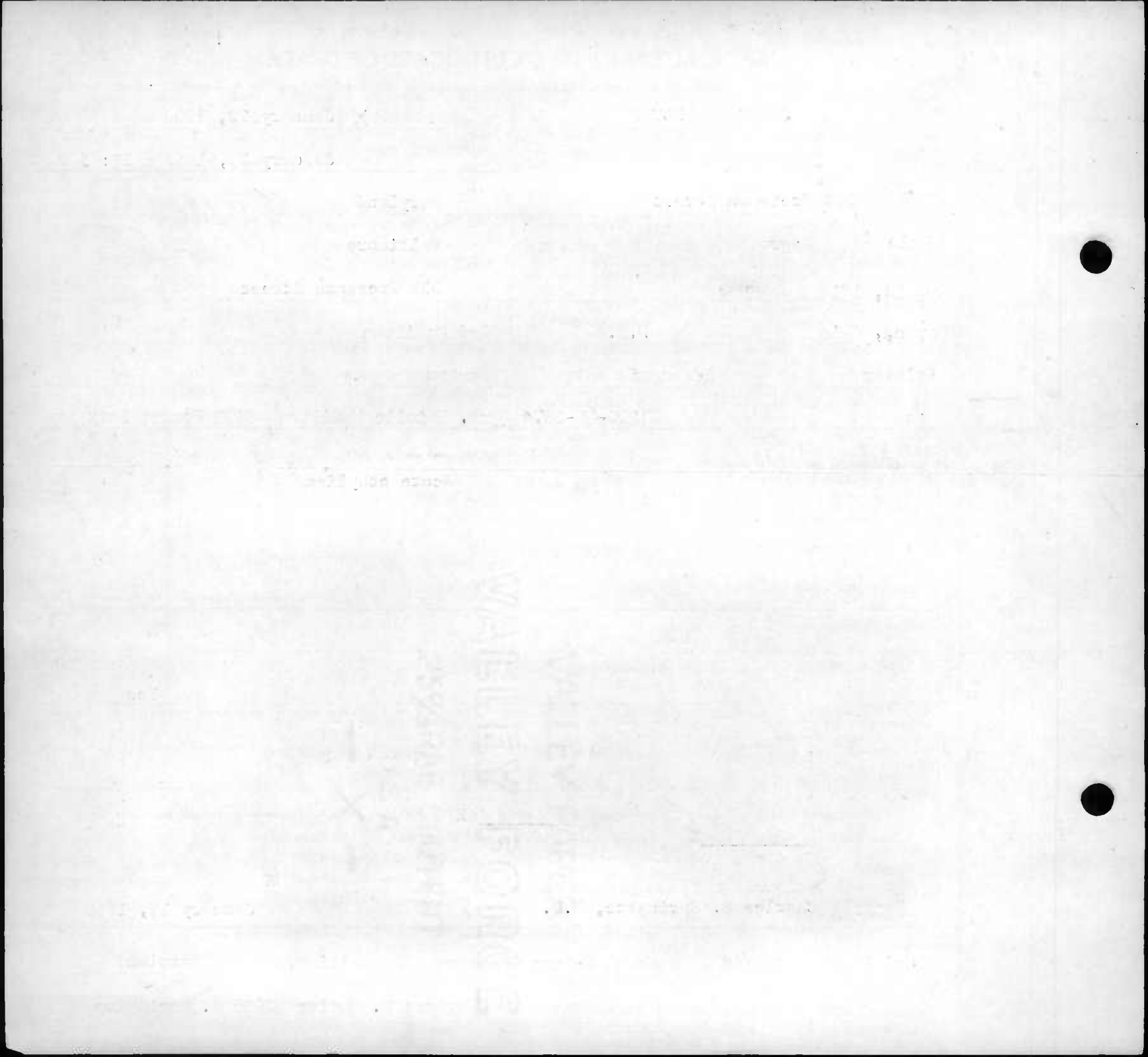


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES HAMILTON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> January 28, 1968 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 338 Pressman Street		3. DATE PRONOUNCED DEAD Month Day Year Hour January 28, 1968 12:05 P.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 4-03			
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore
9. DATE OF BIRTH Aug 14, 1918		10. AGE (In years last birthday) 49	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) Dayton, Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	E. STREET AND NUMBER 338 Pressman Street
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		14B. KIND OF BUSINESS OR INDUSTRY Edmondale Apts	15. MOTHER'S MAIDEN NAME Gertrude Jones
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 220-05-3874	18. INFORMANT ADDRESS Mrs. Estelle Hamilton 3403 Forest Park Ave
19. 303.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute ethylism (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II 322.0 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED January 29, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/2/68	24C. NAME OF CEMETERY or CREMATORY Mount Auburn Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore Maryland			
25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		25B. NAME OF REGISTRAR Robert E. Finkbeiner	25C. FUNERAL DIRECTOR ADDRESS Herbert E. Nutter 3035 W. North Ave



68-1449

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-1449

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

PRANAS (FRANK) ~~MONTELOSS~~

2. DATE

Known ☒

Month

Day

Year

Hour

OF

Estimated ☐

1

30

68

5:55 p

M.

3. DATE

Month

Day

Year

Hour

PRONOUNCED DEAD

January 30

1968

5:55 p M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Balto.

YES ☒No ☐

E. STREET AND NUMBER

806 1/2 W. Lombard St.

18-03

9. DATE OF BIRTH

8-7-1915

10. AGE (In years

last birthday)

52

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

LITHUANIA

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work

done during most of working life, even if retired)

Kitchen Help

14B. KIND OF BUSINESS OR INDUSTRY

Motel

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give year or dates of service)

No

No

17. SOCIAL SECURITY NO.

214 38 2766

18. INFORMANT

ADDRESS

PERSONAL PAPERS-

19.

519.9

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Chronic lung disease
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

2

YES

22A. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIB-UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 31, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

2/2/68

24C. NAME OF CEMETERY or CREMATORY

London Park Cem

24D. LOCATION

(City, town, or county)

(State)

Frederick - Belts Md

25A. DATE REC'D BY HEALTH DEPT.

FEB 5 1968

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Thomas J. Kenny Inc Belts Md

8-7-1912
LITHOGRAPH
HOLLISTER
NO. 10

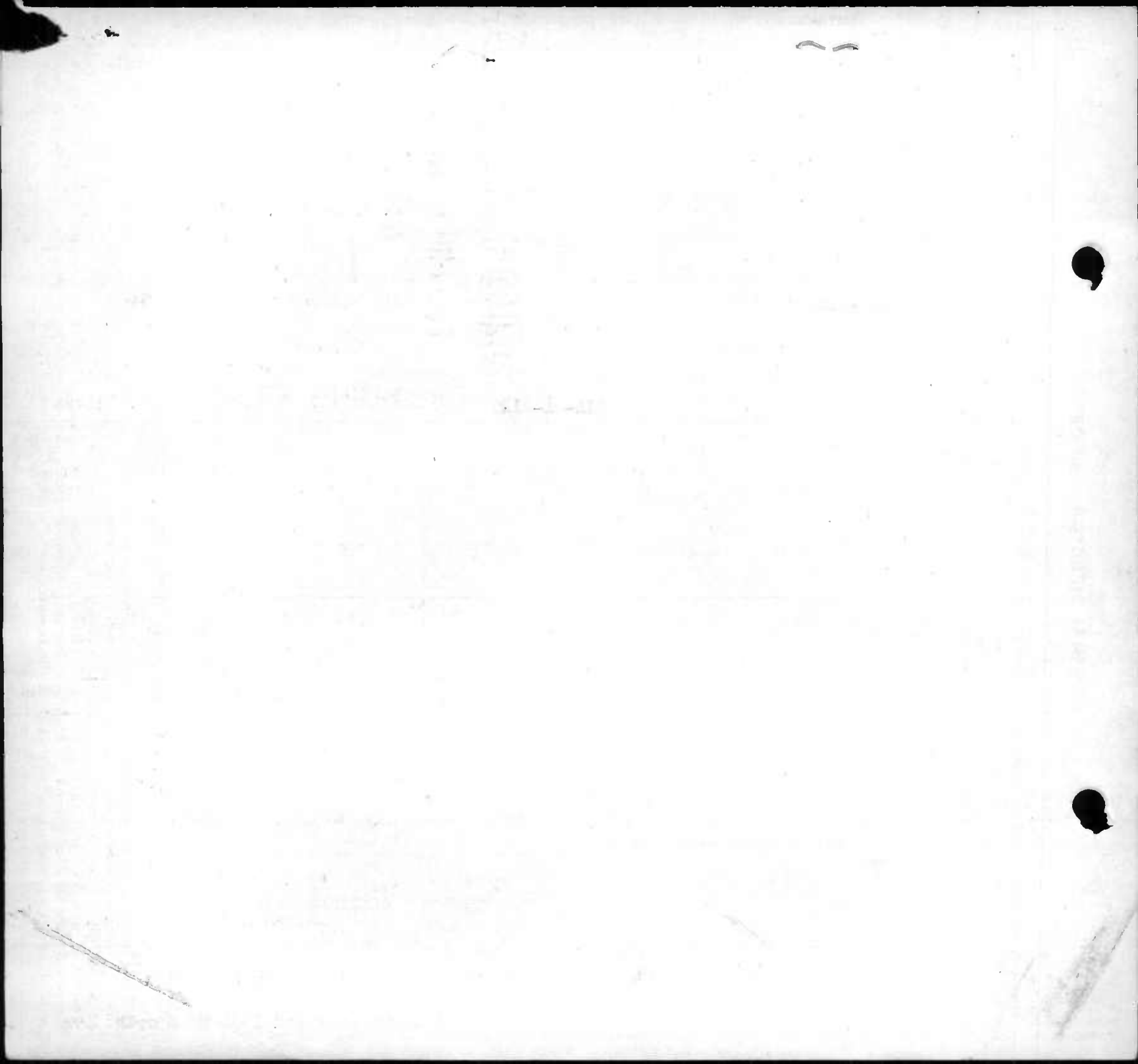
BRISTOL
STREET
LONDON
W.C.2

50-74-00
ME

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 520				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 68-1450	
1. NAME OF DECEASED (Type or Print) Nathaniel Jones				2. DATE AND HOUR OF DEATH 1/29/68				9:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OF RESIDENCE) 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE MARYLAND				A. STATE MARYLAND		B. COUNTY 18-01			
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER 819 W. FAYETT ST. 21201					
5. SEX MALE		6. RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-8-19		9. AGE (In years lost birthday) 48	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ALLEN				14. MOTHER'S MAIDEN NAME LUCINDER					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 214-24-8127		17. INFORMANT ADDRESS RECORD, BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE MD. 21224			
18. 162.1 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CA lung ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 163x II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CA lung (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months	
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 1/29 12/29/67 19 to 1/29 1988, that (1) (we) last saw the deceased alive on 1/29 1988 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Franklin G. Strange				OEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/29/68	
23C. PHYSICIAN'S NAME (Type) Franklin G. Strange				OEGREE		23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE MD. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/6/68		24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A A County Md			
25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968				25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR ADDRESS Adolphus Halstead 1206 W North Ave			



1
e-160

68-1451

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-1451

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MELVIN COOPER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> February 2, 1968 7:15 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00417 W. Biddle Street (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour February 2, 1968 7:15 P. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 11-03	
9. DATE OF BIRTH 3/23/33		10. AGE (In years last birthday) 36 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Elinor	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Helper		14B. KIND OF BUSINESS OR INDUSTRY Truck	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes W W 2		17. SOCIAL SECURITY NO.	
18. INFORMANT Mrs Elinor Brickhouse		ADDRESS 3300 Archentrolly	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Tuberculosis, Active ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 002.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH terrace	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2-3-68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/7/68	
24C. NAME OF CEMETERY or CREMATORY National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR A Halstead		ADDRESS 1206 W North Ave	

3/23/33

Baltimore, Md

U S A

Editor

Friend

My dear

Dear Sir, I have just received your letter of the 23rd inst.

and am glad to hear from you.

Sincerely,
John Edgar Hoover

John Edgar Hoover

Respectfully,
John Edgar Hoover

Director

Federal Bureau of Investigation

Washington, D. C.

A Release of 1908 is now available

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 1452 CERTIFICATE OF DEATH

REG. NO.

68- 1452

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ANNA MARIE AUGUSTINE

2. DATE AND HOUR OF DEATH

2-5-68

8⁰⁰ A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

2020 E LOMBARD ST

5. SEX

F

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

11-04-90

9. AGE (In years lost birthday)

77

If Under 1 Yr. Months: Days

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

AUSTRIA

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

WILLIAM BLOSL

14. MOTHER'S MAIDEN NAME

BARBARA SCHANO

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

21-07-0033B

17. INFORMANT

GEORGE J AUGUSTINE 2020 E LOMBARD ST

ADDRESS

18. I

531.0

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

GI Hemorrhage &

4 DAYS

(B) DUE TO, OR AS A CONSEQUENCE OF:

Shock from Gastric ulcer

(C)

Pulmonary edema

4 DAYS

MEDICAL CERTIFICATION

3-40.0

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 02-01-1968 to 2-5-1968, that (I) (we) last saw the deceased alive on 2-5-1968 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.

23A. SIGNATURE

Saravut Srfuengfung MD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

2-5-68

23C. PHYSICIAN'S NAME (Type)

S Saravut Srfuengfung

23D. ADDRESS

Union Memorial Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

FEB 8 68

24C. NAME OF CEMETERY OR CREMATORY

HOLY REDEEMER CEM.

24D. LOCATION

4430 BELAIR RD

(State)

MD

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

DIPPEL BROS INC 1800 E LOMBARD ST

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1453

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-1453

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Stanley R. Kramer, Sr.

2. DATE AND HOUR OF DEATH

Feb. 3, 1968

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

3716 Chesholm Rd. # 16

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

3716 Chesholm Rd. # 21216

5. SEX

Male

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

Dec. 2, 1886

9. AGE (In years
last birthday)

81

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Postal Clerk

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Dartown, Ohio

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Paul Kramer

14. MOTHER'S MAIDEN NAME

Gerber

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Stanley R. Kramer-3608 Oak Lane #212D7

18. 410.9 + 250.9
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

MYOCARDIAL INFARCTION

3 DAYS

(B) ARTERIOSCLEROTIC HEART DISEASE

DUE TO, OR AS A CONSEQUENCE OF:

2 YEARS

(C) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

DIABETES MELLITUS

18 MOS.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from APRIL 12, 1968 to FEB. 3, 1968,
that (I) (we) last saw the deceased alive on JAN. 11, 1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Marvin Goldstein

DEGREE

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

2/5/68

23C. PHYSICIAN'S
NAME (Type)

MARVIN GOLDSTEIN, M.D.

DEGREE

23D. ADDRESS

6001 PARK HEIGHTS AVE. BALTO., MD.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

2-7-68

24C. NAME OF CEMETERY OR CREMATORY

Lorraine Cemetery

24D. LOCATION

Baltimore, Maryland

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

FEB 5 1968

Ellsworth Armacost-4600 Liberty Hgts. Ave

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. X		68-1454	
BIRTH NO. 10-512				68-1454			
1. NAME OF DECEASED (Type or Print) ANNA R. CUMPSTON				2. DATE AND HOUR OF DEATH 2-2-68 1.00 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE DISTRICT OF COLUMBIA B. COUNTY V-48			
				C. CITY OR TOWN WASHINGTON		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1657 31st STREET		20007	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-27-92	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Salem, VA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME EDWARD CUMPSTON				14. MOTHER'S MAIDEN NAME ANNA RAMSEY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Edward H Cumpston - 1600 East Ave ADDRESS Rochester NY 14610		
18. 574.1 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Renal failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
				(B) Cardio respiratory collapse. DUE TO, OR AS A CONSEQUENCE OF:		6 days	
				(C) Post op cholecystectomy		8 days	
18. 578.4X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Resistant Carcinoma of breast		8 years	
19A. DATE OF OPERATION 31-24-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cholecystitis & cholelithiasis		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1-22 19 68 to 2-2 19 68 , that (I) (we) lost saw the deceased alive on 2-2 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Carl E Bredenberg M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 2-2-68	
23C. PHYSICIAN'S NAME (Type) CARL E. BREDEBERG				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 2-6-68		24C. NAME OF CEMETERY OR CREMATORY Lowdon Park Crematory		24D. LOCATION (City, town, or county) (State) Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR ADDRESS Ellsworth Agmacost - 4600 Lib Hgts Ave			

1010

on cat

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1455		BALTIMORE CITY HEALTH DEPARTMENT		68- 1455	
BIRTH NO.		M.E. CASE NO.		Registered No.	
1. NAME OF DECEASED (Type or Print) <i>DORA WEST</i>		2. DATE AND HOUR OF DEATH <i>2-1-68</i> <i>2</i> <i>30</i> <i>A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Swan Hosp. of Baltimore</i>		A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		D. STREET ADDRESS (If rural, give location) <i>5500 Wilman Ave</i>			
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>11-19-00</i>	9. AGE (In years last birthday) <i>67</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>214-209083</i>		17. INFORMANT ADDRESS <i>Mrs. Mary White 2513 Linda Ave.</i>	
18. <i>398X</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Pulmonary Edema</i> DUE TO (B) <i>Rheumatic Heart Disease</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1-28</i> 19 <i>68</i> to <i>2-1</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>2-1</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Larry Kreftman M.D.</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>2-1-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>GARY KREFTMAN</i>		23D. ADDRESS <i>Swan Hosp. of Baltimore</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>B</i>		24B. DATE <i>2-5-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>mt Auburn</i>	
24D. LOCATION (City, town, or county) (State) <i>Balt md</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>FEB 5 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Talley</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Joseph C. Russ 2222 N North Ave</i>	

1870

2nd-1870 for May 1870

1
4-543

68- 1456 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 1456
REG. NO.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) RAYMOND H. HAMILTON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour January 31, 1968 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 325 N. Carey Street		3. DATE PRONOUNCED DEAD Month Day Year Hour January 31, 1968 8:40 P. M.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 18-02	
6. SEX Male	7. RACE Negro	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 6-2-02		10. AGE (In years last birthday) 66	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 325 N. Carey Street
11. BIRTHPLACE (State or foreign country) MD. BALTO.		12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME JOHN H. HAMILTON	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME UNKNOWN	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes		17. SOCIAL SECURITY NO. 212-46-3548		18. INFORMANT MARCIE HAMILTON ADDRESS 325 N. Carey St.	
19. CAUSE OF DEATH 412.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 422.1					
20A. DATE OF OPERATION 6		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY? (Yes or No) No
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED February 1, 1968					
24A. BURIAL CREMATION, REMOVAL (Specify) B		24B. DATE 2-5-68	24C. NAME of CEMETERY or CREMATORY Balt Nat Ce		24D. LOCATION (City, town, or county) 5500 Frederick Ave Baltimore
25A. DATE REC'D BY HEALTH DEPT. FEB 5 1968		25B. NAME OF REGISTRAR Robert E. Fairley		25C. FUNERAL DIRECTOR Barney V. Boyer ADDRESS 5127 Carrollton Ave Joseph C. Rumm ADDRESS 212 W. North Ave	

JOHN H. HAMILTON

6-2-02

MD. BALTO.

UNKNOWN

212-48-388 MARCIE HAMILTON

yes

MARILENE MORRIS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1457

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-1457

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

SALVATORE

CAPITANO

2. DATE AND HOUR OF DEATH

Feb. 3, 1968.

8:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

917 E. Belvedere Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Md.

C. CITY OR TOWN

Baltimore

E. STREET AND NUMBER

917 E. Belvedere Avenue

INSIDE CITY LIMITS?

YES ☒NO ☐

5. SEX

Male

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

April 14, 1886.

9. AGE (In years
last birthday)

81

If Under 1 Yr.

Months: Days:

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired Tailor

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Augustino Capitano

14. MOTHER'S MAIDEN NAME

Maria C. Cariota

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

215-07-5138

17. INFORMANT

Mrs. Maria S. Capitano

ADDRESS

(Same)

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1949 to 1/23 1968.
that (I) (we) last saw the deceased alive on 1/23 1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

James R. Karns MD

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

2/5/68.

23C. PHYSICIAN'S
NAME (Type)

James R. KARNs MD

23D. ADDRESS

501 Medical Arts Bldg. Balto

24A. BURIAL CREMATION

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Buried
in Cemetery

2/7/68

Moreland Pk Mausoleum

Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.

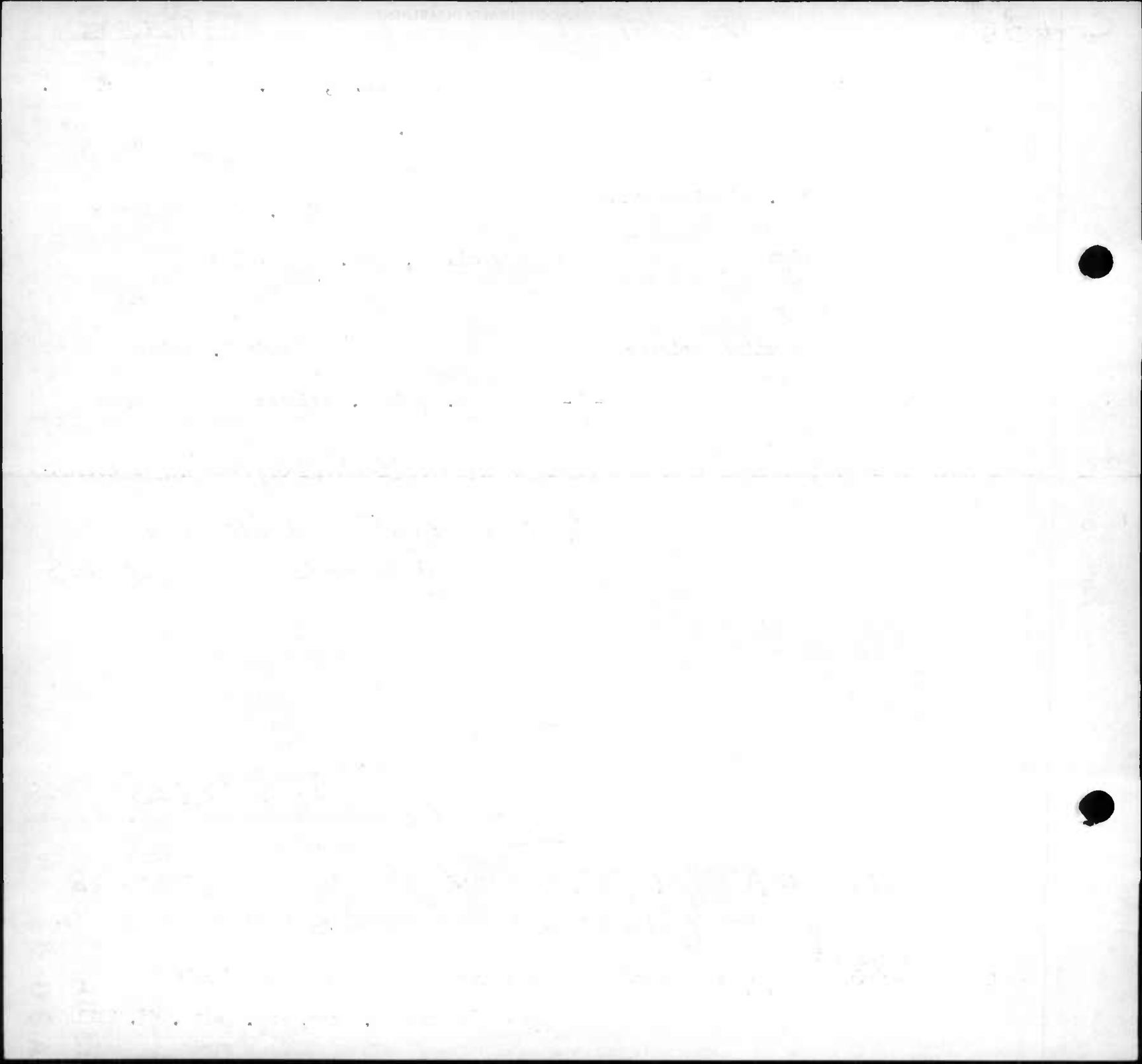
25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

FEB 7 1968 Robert E. Fairbank

Leonard J. Ruck, Inc. Balto. Md. 21214



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1458

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 1458

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>John C. Greenberg</u>		2. DATE AND HOUR OF DEATH <u>2 February 1968</u> <u>8:20 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Church Home & Hospital</u> <u>35 BALTIMORE, Md</u>			A. STATE <u>Maryland</u> B. COUNTY <u>Balt., Md.</u> C. CITY OR TOWN <u>Balt., Md.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1190 W. Belvedere Ave</u> <u>Balto. Md</u>		
5. SEX <u>M</u>	6. RACE <u>CAUC</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-8-98</u>	9. AGE (In years last birthday) <u>69</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Buyer</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md</u>
13. FATHER'S NAME <u>Michael Greenberg</u>			14. MOTHER'S MAIDEN NAME <u>Yetta Trip</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-10-5353</u>	17. INFORMANT <u>Mrs Elaine Lee Greenberg</u>		
18. <u>204.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Chronic Lymphocytic Leukemia</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Congestive Heart Failure</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C).....			ADDRESS <u>Same</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. <u>204.0</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 31</u> 19 <u>68</u> to <u>Feb 2</u> 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>Feb 2</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Rodelio M. Lim</u>				23B. DATE SIGNED <u>2-2-68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Rodelio M. Lim</u>				23D. ADDRESS <u>CH # Church Home & Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>2-4-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Anshe Emunah Aitz Chaim, Cong Washington, Blvd. Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 7 1968</u>		25B. NAME OF REGISTRAR <u>R. E. Farkas</u>		25C. FUNERAL DIRECTOR <u>Sylvan S. Lewis & Son</u> <u>Memorial Chapel</u>	
25D. ADDRESS <u>P.O. Box 65 Garrison, Md (21055)</u>					

Rebelio H. 1m
in the H. 1m

CH

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Philip George Pope

2. DATE AND HOUR OF DEATH

2/1/68

3:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

4940 Eastern Avenue

Baltimore, Maryland 21224

31 Baltimore City Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore Co

53-00

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

EAST WOOD

YES ☒NO ☒

E. STREET AND NUMBER

7048 Eastbrook Ave, 21224

5. SEX

Male

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

1-25-14

9. AGE (In years
last birthday)

54

If Under 1 Yr.

Months: Days:

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Brewery Worker

10B. KIND OF BUSINESS OR INDUSTRY

AMERICAN BREW. CO.

11. BIRTHPLACE (State or foreign country)

Maryland, BALTIMORE

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Philip POPE

14. MOTHER'S MAIDEN NAME

Angela CUNEO

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

W.W. II

16. SOCIAL
SECURITY NO.

215-01-4448

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue

21224

18. 431.9 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

Cerebral Hemorrhage (Brain Stem)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

8 days + present

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Pneumonia

19A. DATE OF OPERATION

1/23/68

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED

Compressed with depressed right inf. cerebellar artery

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

(If in Baltimore City, give exact location)

(Brain stem Hemorrhage)

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/23 1968 to 2/1 1968,
that (I) (we) last saw the deceased alive on 2-1-19 68 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

B.D. Richman MD

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

2/1/68

23C. PHYSICIAN'S
NAME (Type)

B.D. Richman M.D.

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Md.
Baltimore City Hospital 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

2-5-68

24C. NAME of CEMETERY or CREMATORY

BALTIMORE NATIONAL CEM 5501 FREDERICK AVE, BALTO., MD.

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

FEB 7 1968

25B. NAME OF REGISTRAR

Robert E. Fisher

25C. FUNERAL DIRECTOR

Charles S. Geiler 6224 EASTERN AVE. BALTO., 21224, MD.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Philip Pore
Couso

1-27 H 0-4

1-27 H 0-4

1-27 H 0-4

1-27 H 0-4

1-27 H 0-4

1-27 H 0-4

1-27 H 0-4

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 1460

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BENJAMIN BRUCE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input checked="" type="checkbox"/> January 9, 1968 10:00 A.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1045 Bristol Place		3. DATE PRONOUNCED DEAD Month Day Year Hour February 2, 1968 10:20 A.	
6. SEX male		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE white		C. CITY OR TOWN Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH Sept. 11, 1927		10. AGE (In years lost birthday) 40	
11. BIRTHPLACE (State or foreign country) Danville, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemist		15. MOTHER'S MAIDEN NAME Mary Dodson	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes WWII		17. SOCIAL SECURITY NO.	
18. INFORMANT Townes F.H. Danville, Va.		ADDRESS	
19. 796.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Advanced Decomposition. No Anatomical Cause of Death Ascertained.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) Yes	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2/2/68	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/6/68	
24C. NAME OF CEMETERY or CREMATORY Family Cemetery		24D. LOCATION (City, town, or county) (State) Pittsylvania Co., Va.	
25A. DATE REC'D BY HEALTH DEPT. Feb 1, 1968		25B. NAME OF REGISTRAR Robert E. Felt	
25C. FUNERAL DIRECTOR Wm. J. Tichner & Sons		ADDRESS Baltimore, Md.	

1917
Denville, N. J.
W. A. Bruce
Mary DeLeon
James F. Denville, N. J.

1917
Denville, N. J.
W. A. Bruce
Mary DeLeon
James F. Denville, N. J.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1461

CITY OF BALTIMORE
Baltimore City Health Department
CERTIFICATE OF DEATH

REG. NO.

68- 1461

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2. DATE AND HOUR OF DEATH

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

E. STREET AND NUMBER

YES ☐ NO ☐

5. SEX

6. RACE

7. MARRIED ☐ NEVER MARRIED ☐

8. DATE OF BIRTH

9. AGE (In years
lost birthday)

If Under 1 Yr.
Months Days

If Under 24 Hrs.
Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. 443.0 + 150.9
CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, oshtenio, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

(B) ASVD, Dry gangrene

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At
Work ☐

Not While
At Work ☐

22. I certify that (I) (this hospital) attended the deceased from 1/12/68 19 to 2/5/68 19
that (I) (we) last saw the deceased alive on 1/5/68 19 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

DEGREE

Attending
Phys. ☐

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

23C. PHYSICIAN'S
NAME (Type)

23D. ADDRESS

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

2547 UNIVERSITY

Staple 1409

2547 UNIVERSITY

100

2547

2547

2547

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-1462</u> <u>4</u>	
BIRTH NO. <u>68-02708</u>		68-1462 CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Mosley Baby Boy</u>		2. DATE AND HOUR OF DEATH <u>Feb 5 '68</u> <u>10</u> <u>20</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>CITY OF BALTIMORE</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Johns Hopkins Hospital</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>1829 EAST 29TH STREET</u>		<u>21218</u>	
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-5-68</u>	9. AGE (In years lost birthday) <u>40 minutes</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. <u>40</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Edward Mosley</u>		14. MOTHER'S MAIDEN NAME <u>Regina</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>1829 E 29th St</u>	
18. <u>776.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ATELECTASIS</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>762.0 II</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Feb 5</u> <u>1968</u> to <u>Feb 5</u> <u>1968</u> , that (I) (we) last saw the deceased alive on <u>Feb 5</u> <u>1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert Suskind MD</u>				23B. DATE SIGNED <u>2-5-68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Robert Suskind MD</u>				23D. ADDRESS <u>Johns Hopkins Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u>		24B. DATE <u>2-5-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>JOHNS HOPKINS HOSPITAL</u>	
24D. LOCATION <u>BALTIMORE, MARYLAND</u>		24E. NAME OF REGISTRAR <u>Feb 7 1968</u>		24F. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>Feb 7 1968</u>		25B. NAME OF REGISTRAR <u>Feb 2, 1968</u>		25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1463 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 10

68-1463

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

THOMAS ALBERT GERMAN

2. DATE AND HOUR OF DEATH

4 FEB 68 9 30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

MARYLAND GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND ANNE ARUNDEL Co.

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

HANOVER

YES ☐

NO ☒

E. STREET AND NUMBER

Rt 2 - Box 82 52-00

5. SEX

M

6. RACE

CAUC

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

15 JUNE 07 60

9. AGE (In years last birthday)

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

CHEMIST

10B. KIND OF BUSINESS OR INDUSTRY

DAVIDSON CHEM.

11. BIRTHPLACE (State or foreign country)

BALTO, MD

12. CITIZEN OF WHAT COUNTRY?

U.S. A.

13. FATHER'S NAME

THOMAS GERMAN

14. MOTHER'S MAIDEN NAME

Ann Bell-PRICE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL SECURITY NO.

212-03-9485

17. INFORMANT

THOMAS A. GERMAN JR. BIRTHDAY

ADDRESS

153.81

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) INTESTINAL OBSTR 3° ADENOC

DUE TO, OR AS A CONSEQUENCE OF:

(C) CORONARY ARTERY DISEASE

1 YR POST MI

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that HT (this hospital) attended the deceased from 28 JAN 1968 to 4 FEB 1968, that HT (we) last saw the deceased alive on 4 FEB 1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. HT (We) (did) (did not) view the body after death.

23A. SIGNATURE

J. J. Oldroyd M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

4 Feb 68

23C. PHYSICIAN'S NAME (Type)

J. J. Oldroyd M.D.

23D. ADDRESS

Maryland Gen Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7 Feb 1968

24C. NAME OF CEMETERY or CREMATORY

Cedar Hill Cemetery

24D. LOCATION

Baltimore - Maryland

25A. DATE REC'D BY HEALTH DEPT.

SEP 7 1968

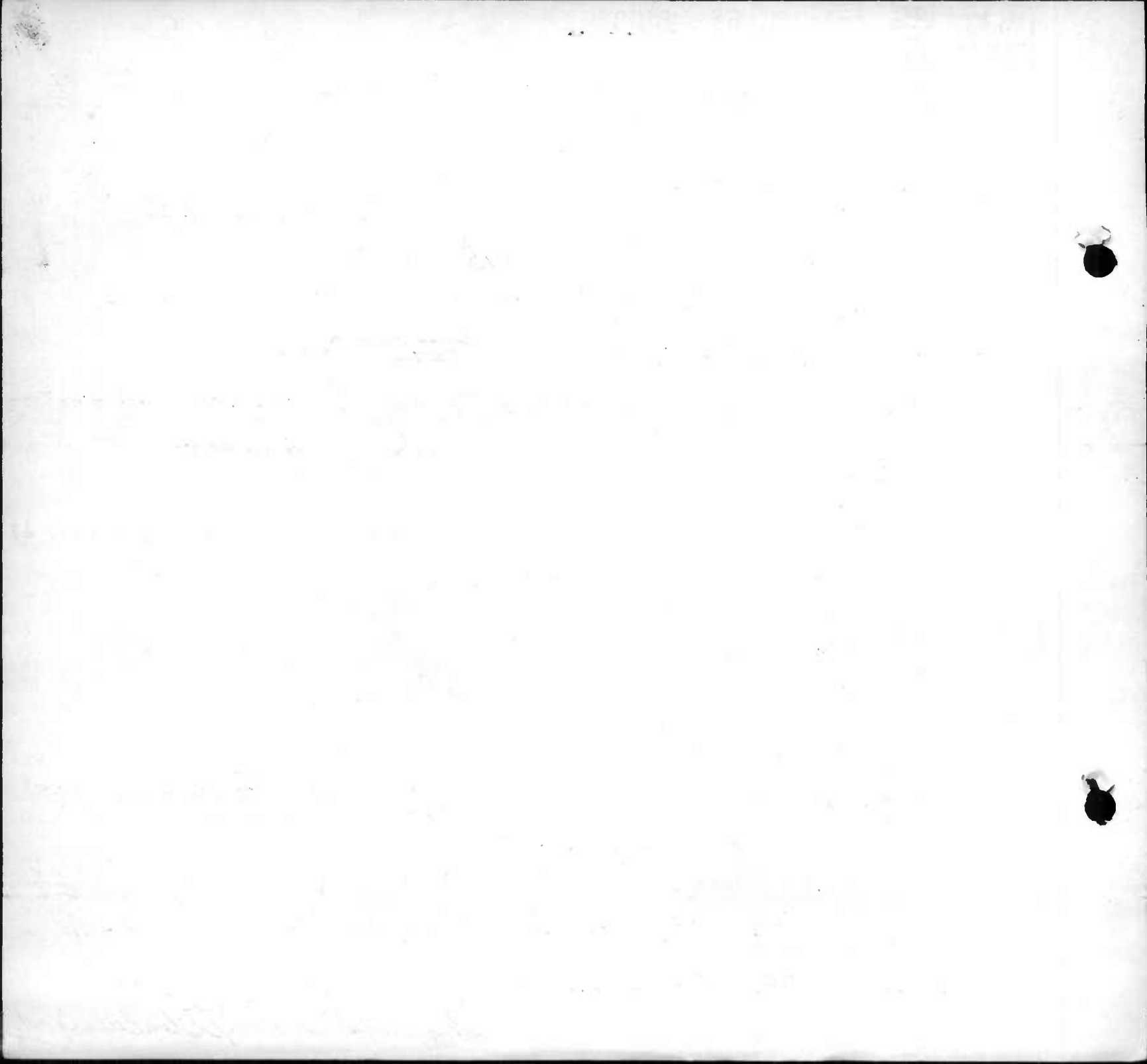
25B. NAME OF REGISTRAR

Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR

Robert E. Farber, M.D.

ADDRESS



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 1464

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOHN HENRY GRADY

2. DATE
OF DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

3. DATE

Month

Day

Year

Hour

M.

PRONOUNCED DEAD

February 1, 1968

9:20 A.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

BALTIMORE

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

6. SEX

Male

7. RACE

White

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☒

9. DATE OF BIRTH

8 NOV 1916

10. AGE (In years
last birthday)

51

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

3157 KEWSICK ROAD

Keswick Rd

11. BIRTHPLACE (State or foreign country)

CUMBERLAND MD.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

BERTRUM GRADY

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

LABORER

14B. KIND OF BUSINESS OR INDUSTRY

CONSTRUCTION

15. MOTHER'S MAIDEN NAME

IDA C. "FISHELL" GRADY

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WWII

17. SOCIAL
SECURITY NO.

219-03-9830

18. INFORMANT

MRS DELLA WAGNER MORNING SIDE DRIVE

ADDRESS CUMBERLAND

MD.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

422.1

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

February 1, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

CREMATION

24B. DATE

FEB 5, 1968

24C. NAME of CEMETERY or CREMATORY

J. WILLIAM LEE'S CREMATORY

24D. LOCATION (City, town, or county)

WASHINGTON D.C.

(State)

25A. DATE REC'D BY HEALTH DEPT.

FEB 7 1968

25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

H. LEE SILCOX 404 DECATUR ST. CUMBERLAND

ADDRESS

8293 (P. 1000)

January 10, 1911

Mr. J. H. ...

...

...

...

...

...

5-6151

68- 1465

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

68- 1465

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Mary G. Scrivner

2. DATE AND HOUR OF DEATH

February 3, 1968

3:30 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Gould Convalesarium

Belair Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

Baltimore Co

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Towson

53-00

D. STREET ADDRESS (If rural, give location)

723 Hillen Road

5. SEX

6. RACE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.

Female

White

Widowed

Dec. 10, 1888

79

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Louis Bedecker

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Family records

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHChronic Myocarditis
Associated Congestive Heart failure
Carcinoma of left breast c. metastases
to brain
Cerebral vascular thrombosis

MEDICAL CERTIFICATION

422.2 II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Hypertension

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At
WorkNot While
At Work22. I certify that (I) (the hospital) attended the deceased from Jan. 16, 1968 to Feb. 3, 1968,
that (I) (we) last saw the deceased alive on Feb. 2, 1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

H. V. Harbold

M.D.

Attending
Phys.Med.
DirectorStaff
Phys.

23B. DATE SIGNED

Feb. 5, 1968

23C. PHYSICIAN'S
NAME (Type)

H. V. HARBOLD

23D. ADDRESS

M.D.

4706 Harford Road Baltimore Md-14

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

Feb. 6, 1968

24C. NAME OF CEMETERY or CREMATORY

Prospect Hill Cemetery

24D. LOCATION

(City, town, or county)

Towson, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

FEB 7 1968

25B. NAME OF REGISTRAR

R. D. E. F. J. J. J.

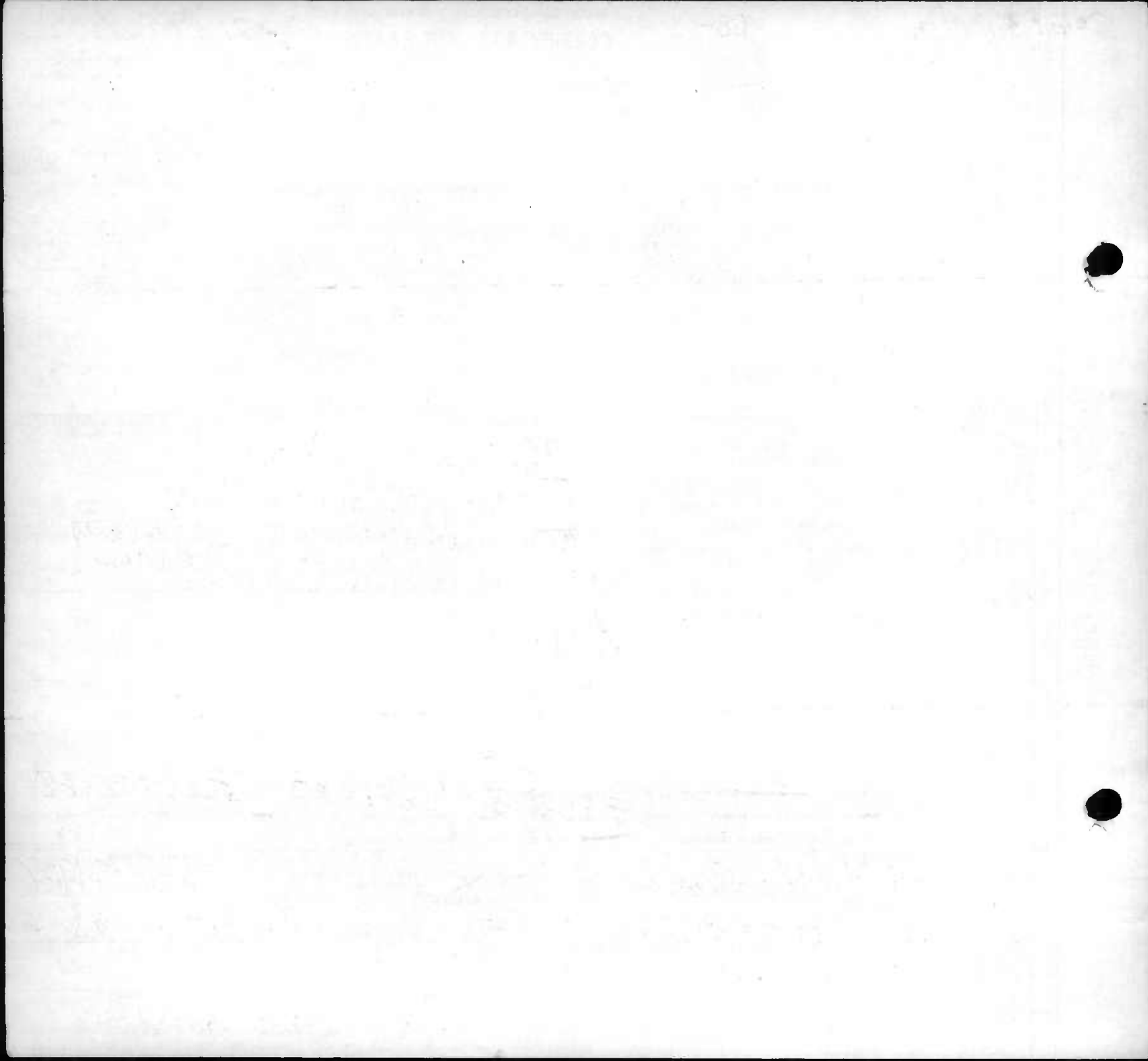
25C. FUNERAL DIRECTOR

John Burns' Sons, Towson, Maryland

ADDRESS

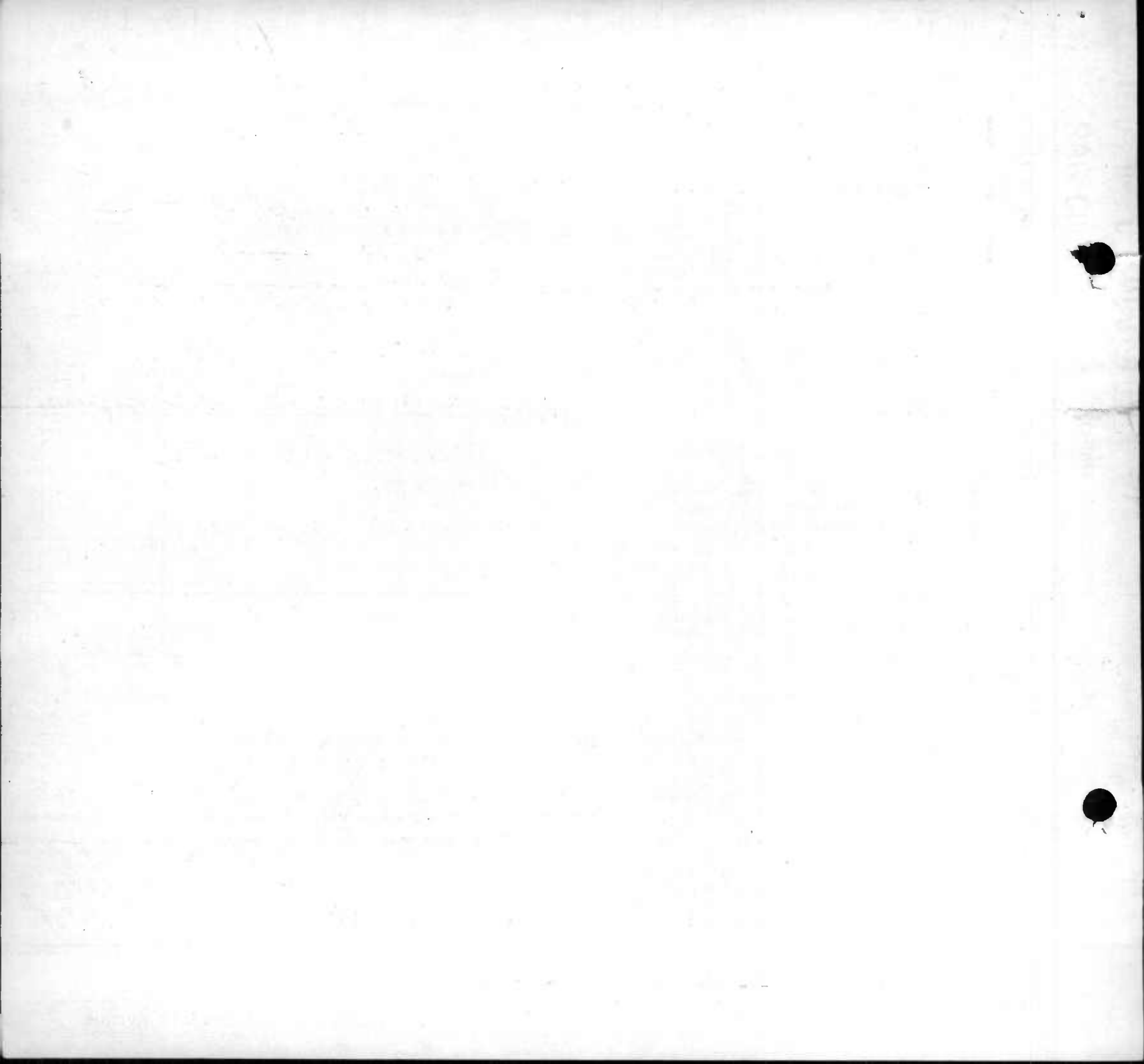
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1466	
68-1466				CERTIFICATE OF DEATH	
BIRTH NO. 563		1. NAME OF DECEASED (Type or Print) DENARDO EVELYN JANE		2. DATE AND HOUR OF DEATH 2-5/68 10:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) FRANKLIN SQUARE Hospital				A. STATE Md. B. COUNTY Baltimore Co. 53-00	
				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 35-16 CORNWALL COURT 22	
5. SEX F	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-14/18	9. AGE (In years last birthday) 49	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ASSEMBLER		10B. KIND OF BUSINESS OR INDUSTRY WESTERN ELECTRIC		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME SABATINO ARMILLEI		14. MOTHER'S MAIDEN NAME ERMINIA PENNONI	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 193-168884		17. INFORMANT DR. H. PAVANO. F.S. Hospital.	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. I 180X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH WIDESPREAD CARCINOMATOSIS					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 1971X II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-3 1968 to 2-5 1968, that (I) (we) last saw the deceased alive on 2-4 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 2-5/68	
23C. PHYSICIAN'S NAME (Type) HERNANDO PAVA MD.				23D. ADDRESS FRANKLIN SQUARE Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-9-1968		24C. NAME OF CEMETERY or CREMATORY Italian Independent Cemetery	
				24D. LOCATION (City, town, or county) Wyoming Pa (State)	
25A. DATE REC'D BY HEALTH DEPT. FEB 7 1968		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR Walter Dabrowski 1005 Dundalk Avenue	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-1467</u>
BIRTH NO. <u>68-1467</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>LE Roy O. JOHNSON</u>		2. DATE AND HOUR OF DEATH <u>FEBRUARY 1 1968</u> <u>4:45</u> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u> <u>2528 FOSTER AVENUE</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>1-03</u>		
		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>2528 FOSTER AVENUE</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-22-1896</u> <u>71</u>	9. AGE (In years last birthday) <u>71</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSPECTOR - GAS</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>GAS-ELECTRIC CO.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>WILLIAM HENRY JOHNSON</u>		14. MOTHER'S MAIDEN NAME <u>ADA LAIDE VIRGINIA ROGERS</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-05-4373</u>		17. INFORMANT ADDRESS <u>MRS. LOUISE JOHNSON 2528 FOSTER AVE</u>
18. <u>185X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> <u>(A) IMMEDIATE CAUSE</u> <u>Carcinoma of prostate gland</u> <u>with metastases to pelvic bones & femur</u> <u>(B) DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(C) _____</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1965</u>		
177X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>Nov.</u> 19 <u>65</u> to <u>Feb 1</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Jan 30</u> 19 <u>68</u> and that in (day) (hour) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>George W. Lippy</u> M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>217 68</u>
23C. PHYSICIAN'S NAME (Type) <u>George W. Lippy</u> M.D.		23D. ADDRESS <u>426 S. Patterson Park Ave Baltimore Md 21231</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>2-5-1968</u>	24C. NAME OF CEMETERY OR CREMATORY <u>OAKLAWN CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND</u>
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 7 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Jarboe</u>		25C. FUNERAL DIRECTOR ADDRESS <u>RAYMOND L. KACZOROWSKI 2525 FLEET ST.</u>

11-12-13

Dear Mr. O. W. W. W.

in answer to your letter of the 11th

of the month of November

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1468

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 1468

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WILLIE BOYD

2. DATE AND HOUR OF DEATH

2/3/68 Noon M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

THE JOHNS HOPKINS HOSPITAL
33 BALTIMORE, MD 21205

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

2143 EDMONDSON AVE

5. SEX

FEMALE

6. RACE

NEGRO

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

10-23-00

9. AGE (In years last birthday)

67

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Not Known

14. MOTHER'S MAIDEN NAME

WILLIAMS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

216-09-4788

17. INFORMANT

Arthur Boyd 2719 Gwynn Falls

ADDRESS

18. 4360 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/1/68 19 68 to 2/3 19 68, that (I) (we) last saw the deceased alive on 2/3/68 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Henry R. Black MD

DEGREE

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type)

HENRY R. BLACK MD

DEGREE

23D. ADDRESS

Johns Hopkins Hosp

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

2-7-68

24C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cem

24D. LOCATION

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

FEB 7 1968

25B. NAME OF REGISTRAR

R. B. E. Edwards

25C. FUNERAL DIRECTOR

Francis H. Hunsley

ADDRESS

5385 Biddle St

134

B-655

68-1469 BALTIMORE CITY HEALTH DEPARTMENT

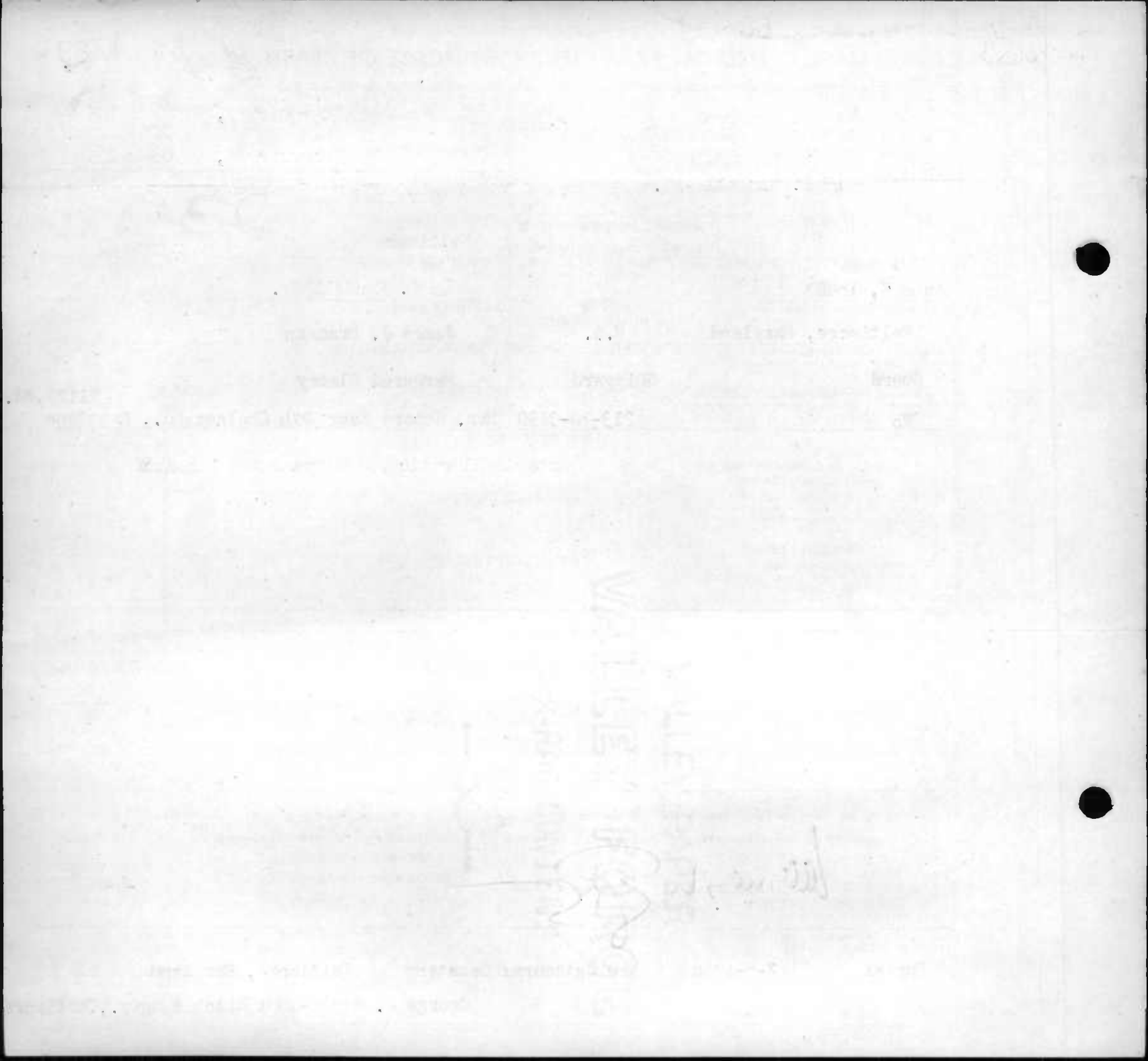
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-1469

BIRTH NO.

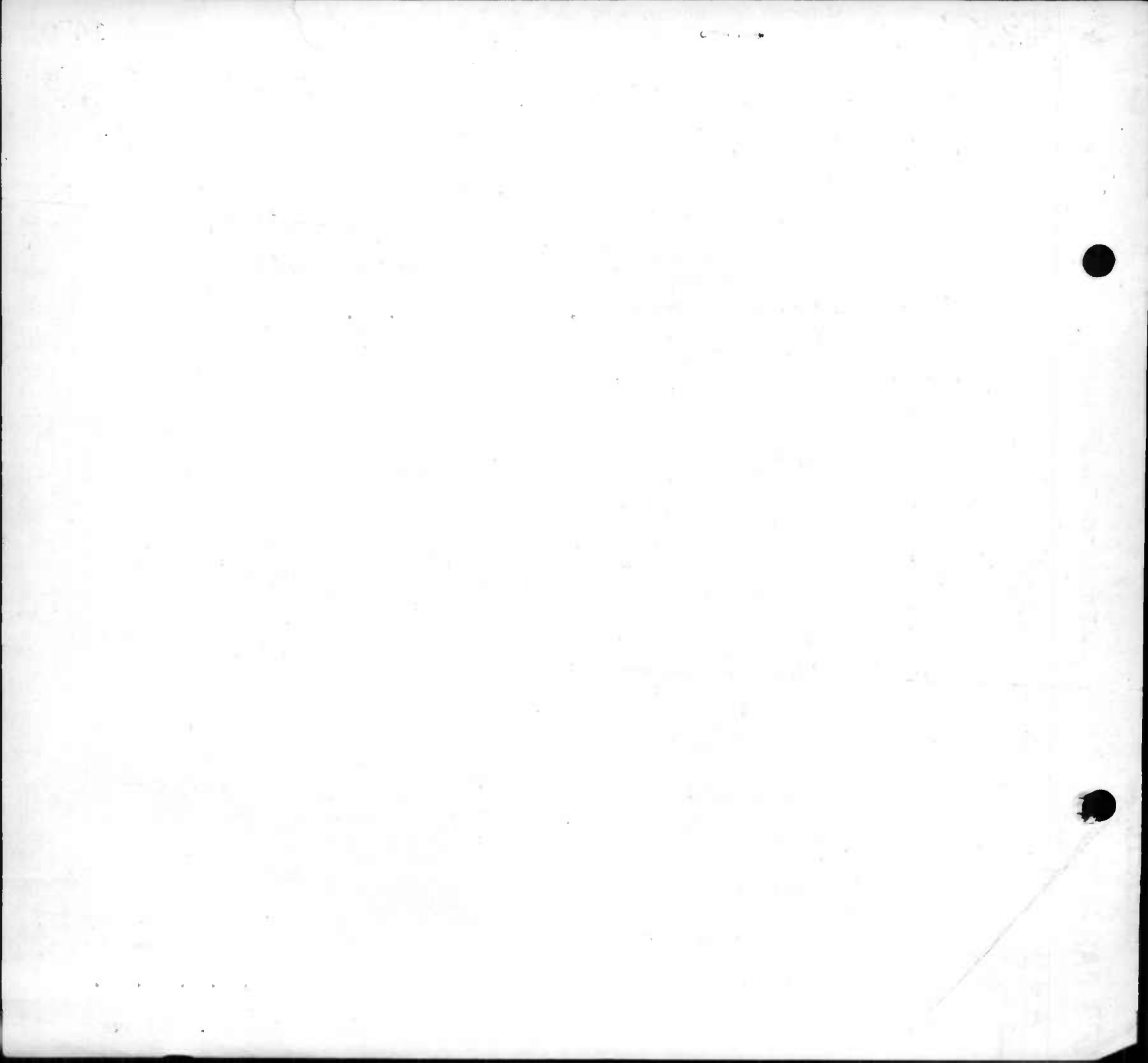
1. NAME OF DECEASED (Type or Print) James E Brannon		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month 2 Day Year Hour Estimated <input type="checkbox"/> Feberuary 3, 1968 105 P M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 49 E. Randall ST.		3. DATE PRONOUNCED DEAD Month Day Year Hour Feberuary 3, 1968 105 P M.	
6. SEX M		7. RACE W	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH June 5, 1888		10. AGE (In years lost birthday) 79	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James J. Brannon		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard	
15. MOTHER'S MAIDEN NAME Margaret Clancy		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 243-20-3190		18. INFORMANT Mrs. Honora Zang	
19. CAUSE OF DEATH 412.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No)		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2-4-68	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-6-1968	
24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. FEB 7 1968		25B. NAME OF REGISTRAR Robert E. Farkas	
25C. FUNERAL DIRECTOR George J. Gonce		ADDRESS 4001 Ritchie Hgwy., Baltimore	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

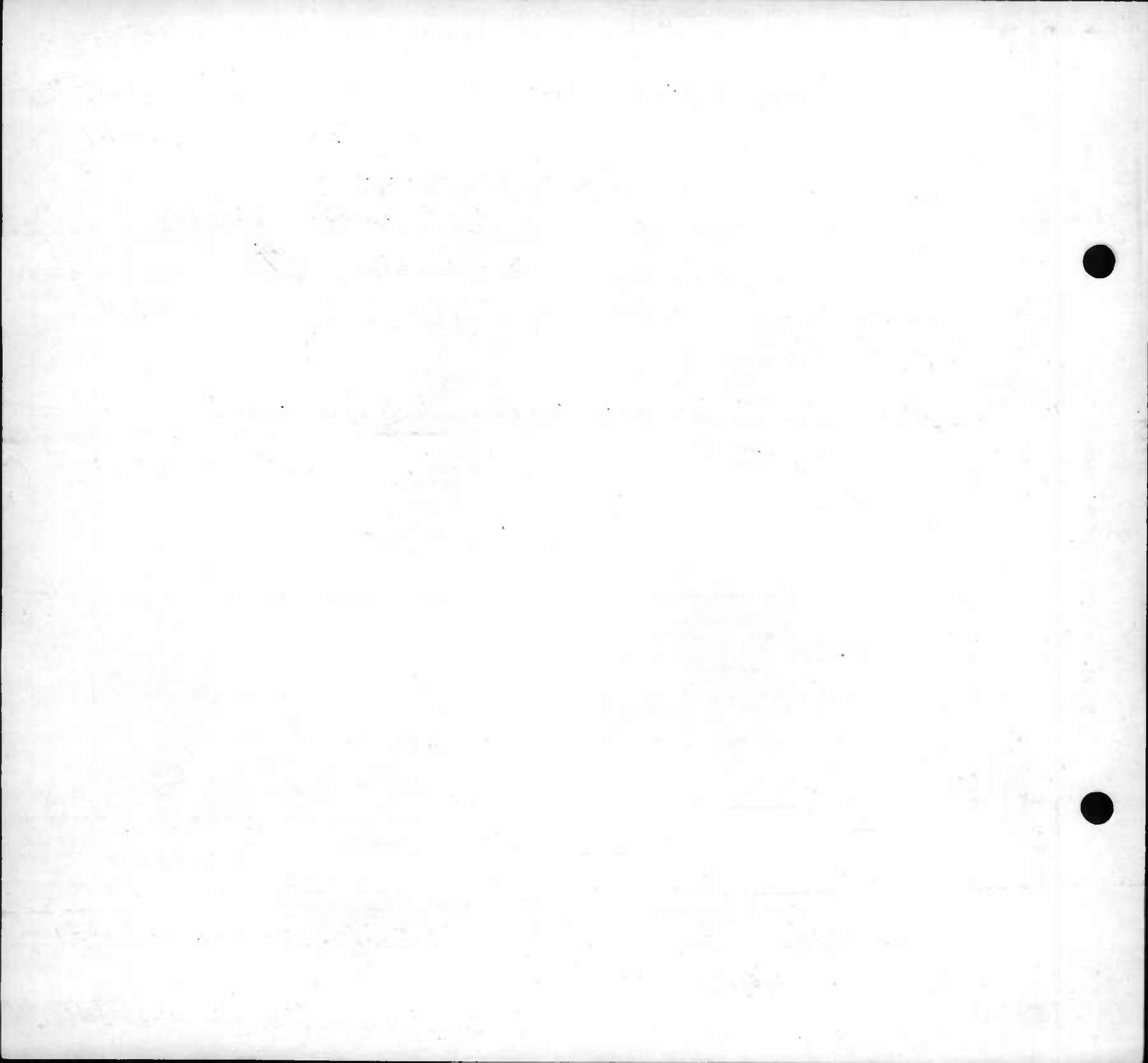
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-1470</u>
BIRTH NO. <u>68-1470</u>				CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) <u>Milton J. SHAMLEFFER</u>		2. DATE AND HOUR OF DEATH <u>Feb 5, 1968</u> <u>8:00</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 Maryland Gen. Hosp</u>		A. STATE <u>MD</u> B. COUNTY		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>1223 CHURCH ST.</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 4, 1896</u>	9. AGE (In years lost birthday) <u>71</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman-Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Fire Dept.</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>
13. FATHER'S NAME <u>William SHAMLEFFER</u>		14. MOTHER'S MAIDEN NAME <u>Rosa HERN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes # 1</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Medical Record</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>C.V.A.</u> <u>Interochastri fracture LD Hip</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
MEDICAL CERTIFICATION				
19A. DATE OF OPERATION <u>Jan 25, 1968</u>				
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Poor - Fr Hip</u>				
20A. AUTOPSY? (Yes or No) <u>No</u>				
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.) <u>Does not know</u>		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u>1 8 68</u>		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>injury was received</u>		
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 8 1968</u> to <u>Feb 5 1968</u> , that (I) (we) last saw the deceased alive on <u>Feb 5 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Youngsik Moon</u>		23B. DATE SIGNED <u>Feb 5, 1968</u>		
23C. PHYSICIAN'S NAME (Type) <u>Youngsik Moon</u>		23D. ADDRESS <u>Maryland Gen. Hosp</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>29 1968</u>		24C. NAME OF CEMETERY or CREMATORY <u>Glen Haven</u>
24D. LOCATION (City, town, or county) (State) <u>Glen Burnie, A. A. Co. Md.</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 7 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber</u>		25C. FUNERAL DIRECTOR <u>Mc Cully</u>
				ADDRESS <u>130 E. Fort Ave</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 7
1. NAME OF DECEASED (Type or Print) Gross, Doris WARREN		2. DATE AND HOUR OF DEATH 2-6-68 3:45 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION North Charles General Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 524 Chabot Square 53-00		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1-25-04	9. AGE (In years last birthday) 64
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maine
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Bert Parker		
14. MOTHER'S MAIDEN NAME ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 217-56-8667		17. INFORMANT NCGH chart		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 513X I		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 321X II		(A) IMMEDIATE CAUSE Left pulmonary abscess DUE TO, OR AS A CONSEQUENCE OF:		
		(B) Pulmonary atelectasis - DUE TO, OR AS A CONSEQUENCE OF:		
		(C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (<u>this hospital</u>) attended the deceased from 1-19 19 68 to 2-6 19 68 , that (I) (<u>we</u>) lost saw the deceased olive on 2-6-1968 and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>We</u>) (<u>did</u>) (<u>did not</u>) view the body after death.				
23A. SIGNATURE Leopoldo Gross, M.D.		23B. DATE SIGNED 2-6-68		23C. PHYSICIAN'S NAME (Type) Leopoldo Gross, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 2/6/1968		24C. NAME OF CEMETERY OR CREMATORY GREEN MOUNT
24D. LOCATION (City, town, or county) (State) BALTIMORE, Md.		25A. DATE REC'D BY HEALTH DEPT. FEB 7 1968		
25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR W. Bruce Rodley, Densdale, Md.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1472

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-1472

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Nock, Claude Hobart

2. DATE AND HOUR OF DEATH

February 1, 1968

4:35 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

23 Veterans Administration Hospital
3900 Loch Raven Blvd.
Baltimore, Maryland 21218

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Virginia, Accomack County

C. CITY OR TOWN

Assawoman

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

Assawoman, Virginia

5. SEX

Male

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

9/2/96

9. AGE (In years lost birthday)

71

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Carpenter

10B. KIND OF BUSINESS OR INDUSTRY

Unknown

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

United States

13. FATHER'S NAME

Lee A. Nock

14. MOTHER'S MAIDEN NAME

Nora May Ailsworth

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

5/20/18-10/6/19

16. SOCIAL SECURITY NO.

226-30-29-71

17. INFORMANT

Veterans Hospital Records

Baltimore, Maryland 21218

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

Carcinoma of pyriform sinus with regional metastases

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

6 months

19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

bronchopneumonia

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from February 1, 19 68 to February 1, 19 68, that (X) (we) lost saw the deceased alive on February 1, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.

23A. SIGNATURE

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

February 2, 1968

23C. PHYSICIAN'S NAME (Type)

Ralph H. Twining M.D.

23D. ADDRESS

Veterans Administration Hosp., Balto., Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

2-4-1968

24C. NAME OF CEMETERY or CREMATORY

Assawoman Cemetery

24D. LOCATION

Accomack County, Virginia

25A. DATE REC'D BY HEALTH DEPT.

FEB 7 1968

25B. NAME OF REGISTRAR

Ralph E. Fickens

25C. FUNERAL DIRECTOR

Howard H. Hubbard, 4107 Wilkens Ave. 21229

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68-1473 CERTIFICATE OF DEATH

REG. NO. 68-1473

BIRTH NO. 1600		1. NAME OF DECEASED (Type or Print) KERR, ARTHUR ARNOLD		2. DATE AND HOUR OF DEATH 2-6-68 3:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 36 Franklin Square Hosp				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTIMORE Co C. CITY OR TOWN DUNDALK D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 2902 Liberty parkway	
FULL NAME OF HOSPITAL OR INSTITUTION 36 Franklin Square Hosp		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		5. SEX Male 6. RACE white 7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MASTER MECHANIC		10B. KIND OF BUSINESS OR INDUSTRY STEEL MFGR.		8. DATE OF BIRTH 7-14-1920 9. AGE (In years last birthday) 47	
13. FATHER'S NAME Edward KERR		14. MOTHER'S MAIDEN NAME MARGARET MACCLERY		11. BIRTHPLACE (State or foreign country) PITTSBURGH, PENNA. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-07-6939		17. INFORMANT Sang Bock Lee ADDRESS F. S. H	
18. 412.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) HYPERTENSIVE CARDIOVASCULAR DISEASE				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 473X II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 8 years ago		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED colon ca (?)		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-20 19 68 to 2-6 19 68 , that (I) (we) last saw the deceased alive on 2-30 2-6 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sang Bock Lee M.D.				23B. DATE SIGNED 2-6-68	
23C. PHYSICIAN'S NAME (Type) Sang Bock Lee		23D. ADDRESS 1001 Calhoun St. Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 2/9/68		24C. NAME OF CEMETERY or CREMATORY BELLVUE MEM. PK.	
24D. LOCATION (City, town, or county) (State) DAYTONA BEACH, FLORIDA		25A. DATE REC'D BY HEALTH DEPT. FEB 7 1968			
25B. NAME OF REGISTRAR Robert E. Feltner		25C. FUNERAL DIRECTOR Wilbrook Bradley, Dundalk, Md.			

ADMINISTRATIVE DIRECTIVE
HYPERTEXTIVE

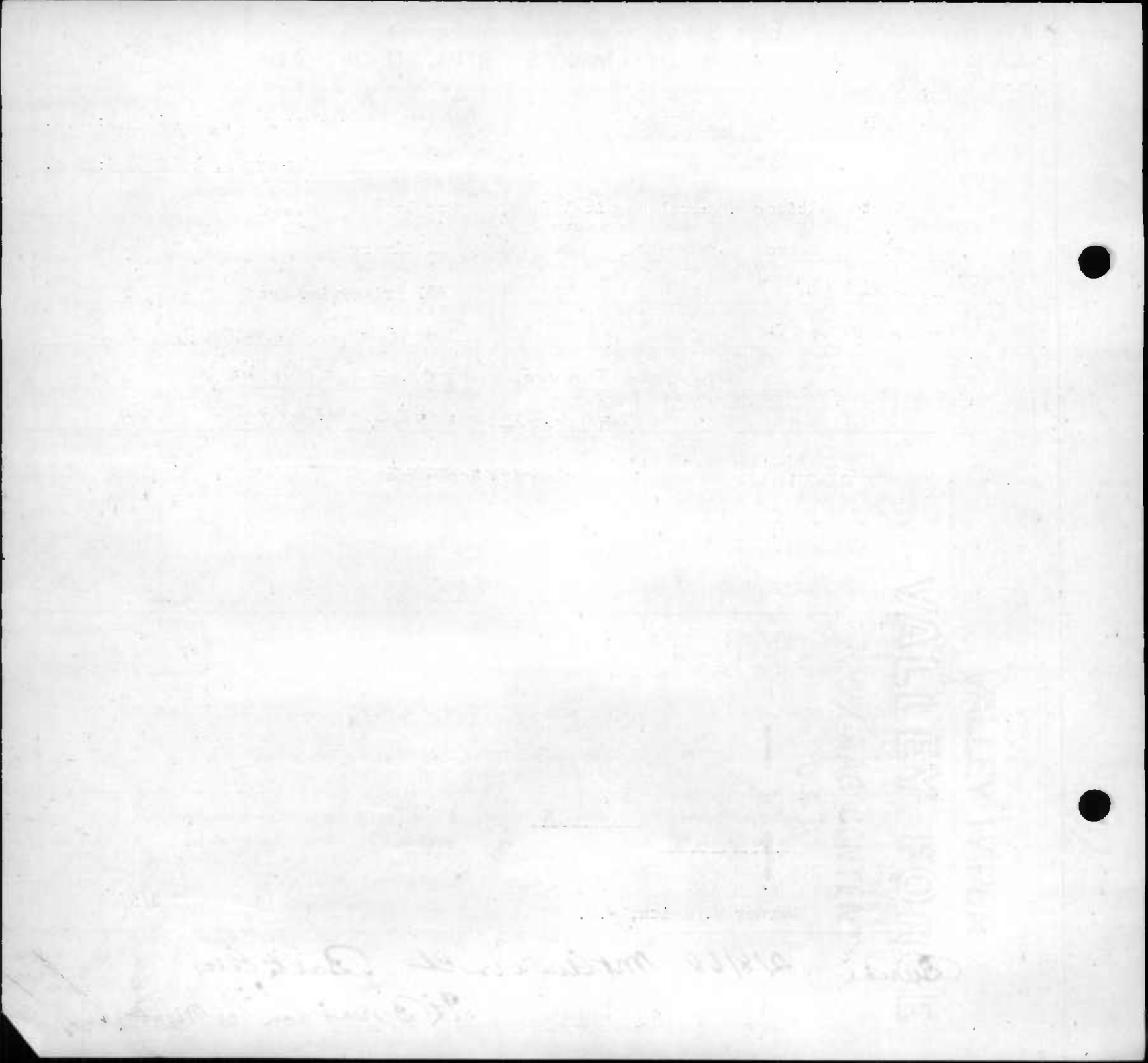
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-1474

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ROSIE HENRY		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> February 5, 1968 9:25 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour February 5, 1968 9:25 A.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 25-32		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX female	7. RACE negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH JUL 22-1921	10. AGE (In years last birthday) 46	E. STREET AND NUMBER 607 Bridgeview Road	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JAMES BLAUMOND		14. MOTHER'S MAIDEN NAME ROSIE PINKNEY	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRAPERY MANUF.		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 214-18-5472	
18. INFORMANT CHARLES HENRY III		ADDRESS S/A	
19. 492X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Pulmonary Emphysema (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) _____			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 527.1 II			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 2/5/68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/8/68	
24C. NAME OF CEMETERY or CREMATORY Mt Auburn Ct		24D. LOCATION (City, town, or county) (State) Balt City	
25A. DATE REC'D BY HEALTH DEPT. FEB 7 1968		25B. NAME OF REGISTRAR W. E. Finkbeiner	
25C. FUNERAL DIRECTOR W. E. Finkbeiner		ADDRESS 108 W. Montgomery St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 68-1475	
BIRTH NO. 68-1475		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HELEN STYSLEY		2. DATE AND HOUR OF DEATH February 6, 1968 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00 627 S. Dean Street		A. STATE Maryland B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 627 S. Dean Street			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH March 4, 1891	9. AGE (In years last birthday) 76	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Austria	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Lev Maynosz		14. MOTHER'S MAIDEN NAME Mary Keller	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-16-3066		17. INFORMANT ADDRESS Michael Stysley 627 S. Dean Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) 250.91		CAUSE OF DEATH (A) Cardiac Decompensation DUE TO (B) Atherosclerosis C.V. DUE TO (C) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 1 mo.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 260X II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 1946 to Feb. 6 1968 , that (I) (we) last saw the deceased alive on Feb. 5 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jason H. Gaskel		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Feb 7, 1968	
23C. PHYSICIAN'S NAME (Type) Jason H. Gaskel, M.D.		23D. ADDRESS 637 S. Conkling St. Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-9-1968		24C. NAME OF CEMETERY or CREMATORY St. Michael Ukrainian	
24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland		25A. DATE REC'D BY HEALTH DEPT. FEB 7 1968			
25B. NAME OF REGISTRAR R. E. E. Farber		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave			

1952

1952

1952

1952

1952

1952

1952

1952

1952

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1476

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-1476

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Carter, Vernon J.		2-4-68 10:15 AM.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
39 Provident Hospital, Inc.				Maryland	
				C. CITY OR TOWN	
				D. INSIDE CITY LIMITS?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				300 E. 25 th Street	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday)
Male	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		12-25-13	54
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Insurance Agent				Baltimore, Maryland	
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?	
Raymond Carter				U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
yes		216140655		Mr. Vernon Carter, Jr.-Son 1237 Kevin Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				Cerebral Hemorrhage	
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Cerebral Intracranial Hemorrhage	
				(B) DUE TO, OR AS A CONSEQUENCE OF:	
				(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Nat. While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from February 3, 1968 to February 4, 1968, that (I) (we) lost saw the deceased alive on February 4, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
N. C. PANCHOLY				2-5-68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		2-9-68		Balto. Nat'l. Cem.	
				Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
FEB 7 1968		Robert E. Taylor, M.D.		Kelson Funeral Home 1348 Calhoun St.	

Handwritten text, possibly a signature or name, appearing in the center of the page.

Handwritten text, possibly a signature or name, appearing in the bottom right corner of the page.

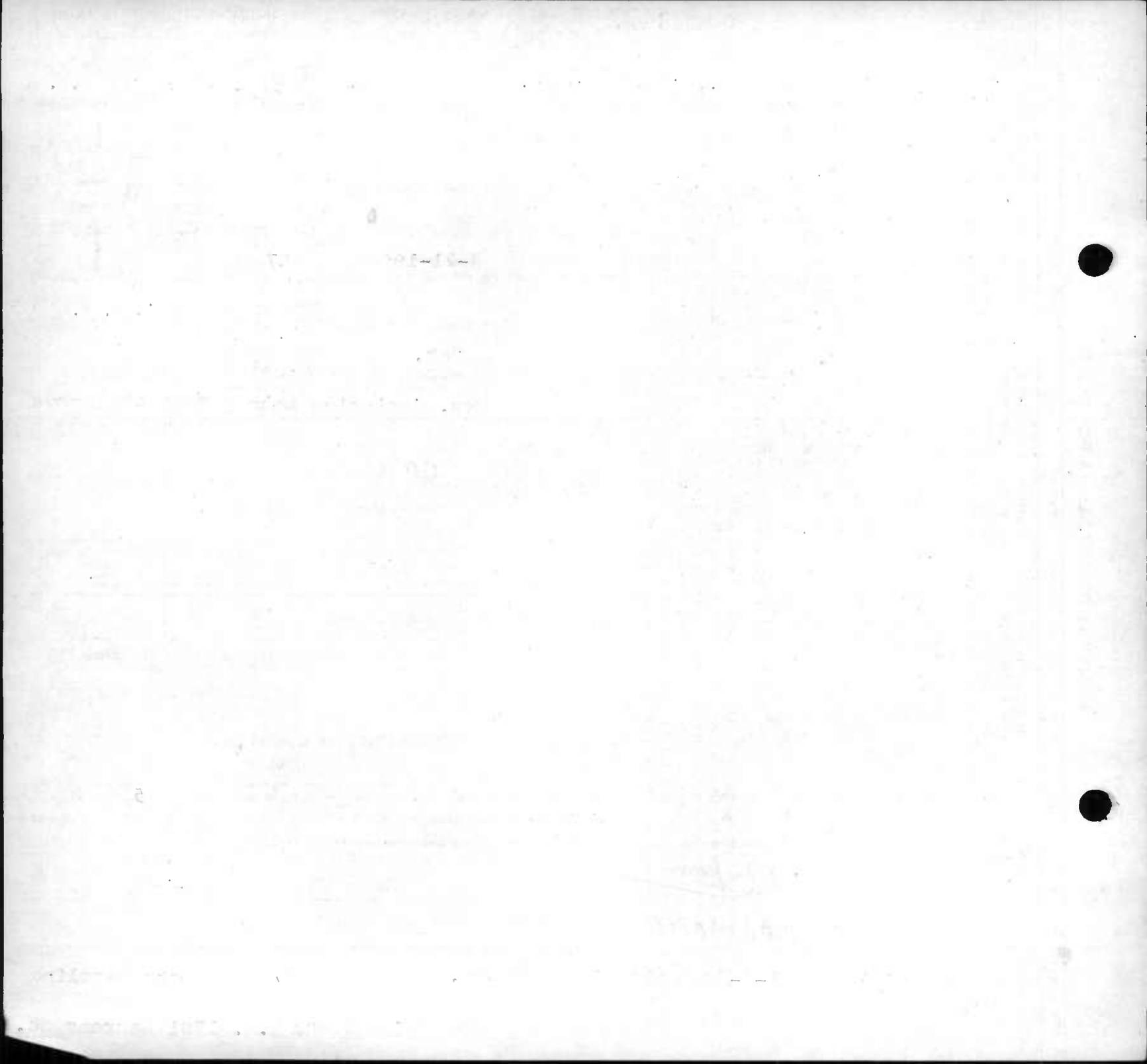
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1477 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-1477

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Pope, Susie (Sue)		2. DATE AND HOUR OF DEATH February 3, 1968 12:50 a.m. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-17		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital 1514 Division Street Baltimore, Maryland		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 5008 Chalgrove Avenue 1478	
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-21-1900	9. AGE (In years last birthday) 67	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Unk.		14. MOTHER'S MAIDEN NAME Unk.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Christine Long	
				ADDRESS 5008 Chalgrove	
18. 150X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) carcinoma of oesophagus.		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: carcinoma of oesophagus.			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
150X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from January 7, 1968 19 to February 3, 1968 , that (I) (we) last saw the deceased alive on February 5, 1968 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE CRJ [Signature]		23B. DATE SIGNED 2-5-68		23C. PHYSICIAN'S NAME (Type) RAJMANE.	
23D. ADDRESS 1514 Division Street		23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 2-6-68	24C. NAME OF CEMETERY or CREMATORY Chapel Grove Cem.		24D. LOCATION (City, town, or county) (State) Weldon, North Carolina	
25A. DATE REC'D BY HEALTH DEPT. FEB 7 1968		25B. NAME OF REGISTRAR Robert S. [Signature]		25C. FUNERAL DIRECTOR MORTON & DYETT F.H.	
				ADDRESS 1701 Laurens St	



BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

John Charles, Jr. (Wesley)

2. DATE AND HOUR OF DEATH

Feb 3 1968

1:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

31

Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
MarylandC. CITY OR TOWN
Baltimore

D. INSIDE CITY LIMITS

YES ☒NO ☐

E. STREET AND NUMBER

3615 Gelston Drive

21216

5. SEX

Male

6. RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH

2-2-1901

9. AGE (In years
last birthday)

67

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unk.

14. MOTHER'S MAIDEN NAME

Unk.

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

215-22-8285A

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue 21224

18. 150X I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:Squamous Cell Carcinoma
of EsophagusDiagnosed
in Sept 1967

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

MEDICAL CERTIFICATION

150X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

SAME

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/27 1967 to 2/3/68 1968
that (I) (we) last saw the deceased alive on 2/3 1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

David H. Huffman MD

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

2/3/68

23C. PHYSICIAN'S
NAME (Type)

David H. Huffman

23D. ADDRESS

Baltimore City Hospitals

4940 Eastern Avenue, Baltimore, Maryland 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

2-7-68

24C. NAME OF CEMETERY OR CREMATORY

Western Star Cem.

24D. LOCATION

Catonville,

(City, town, or county)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

FEB 7 1968

25B. NAME OF REGISTRAR

Robert E. Taylor

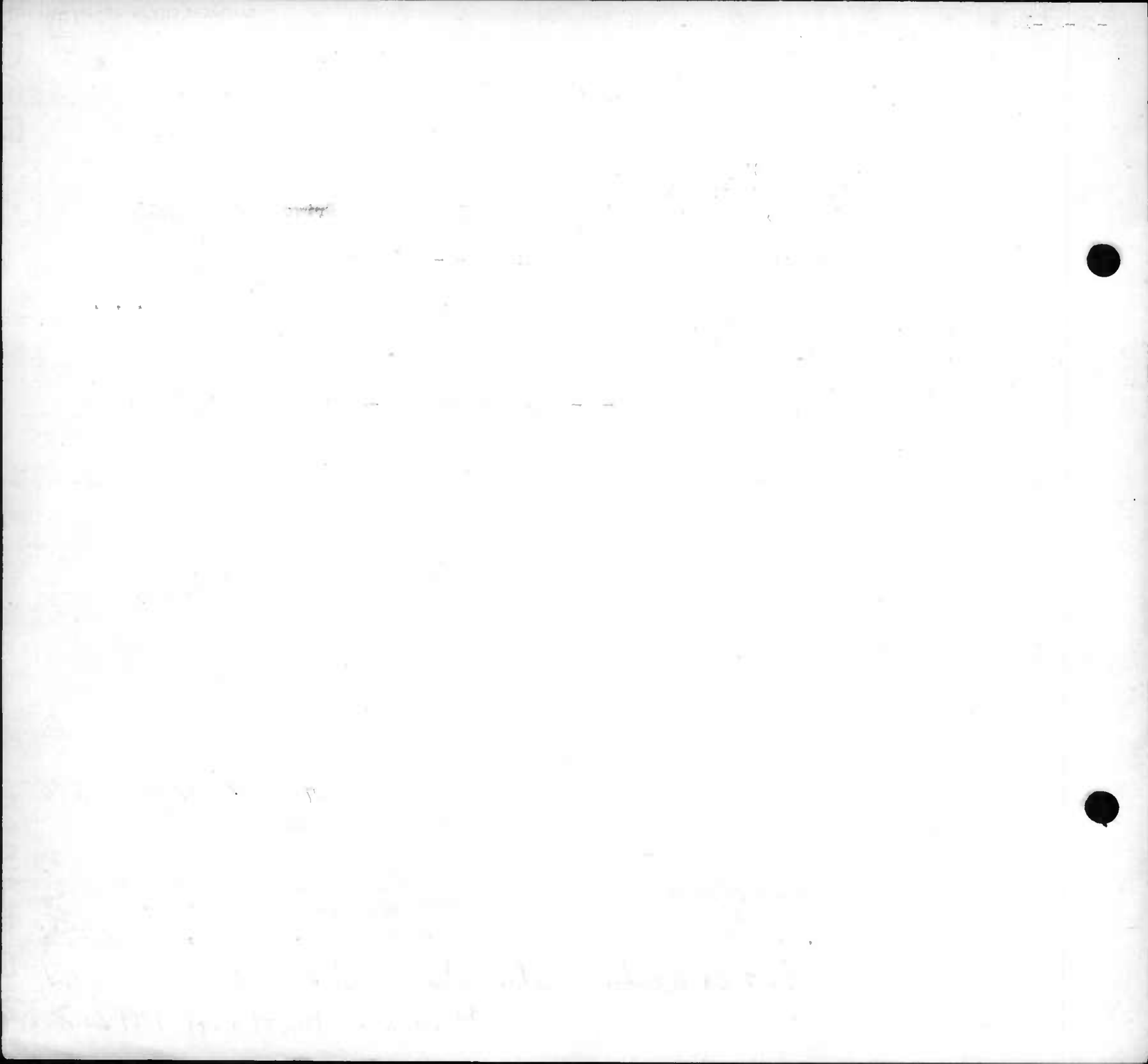
25C. FUNERAL DIRECTOR

Morton E. Dyett F.H. 1701 Laurens

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

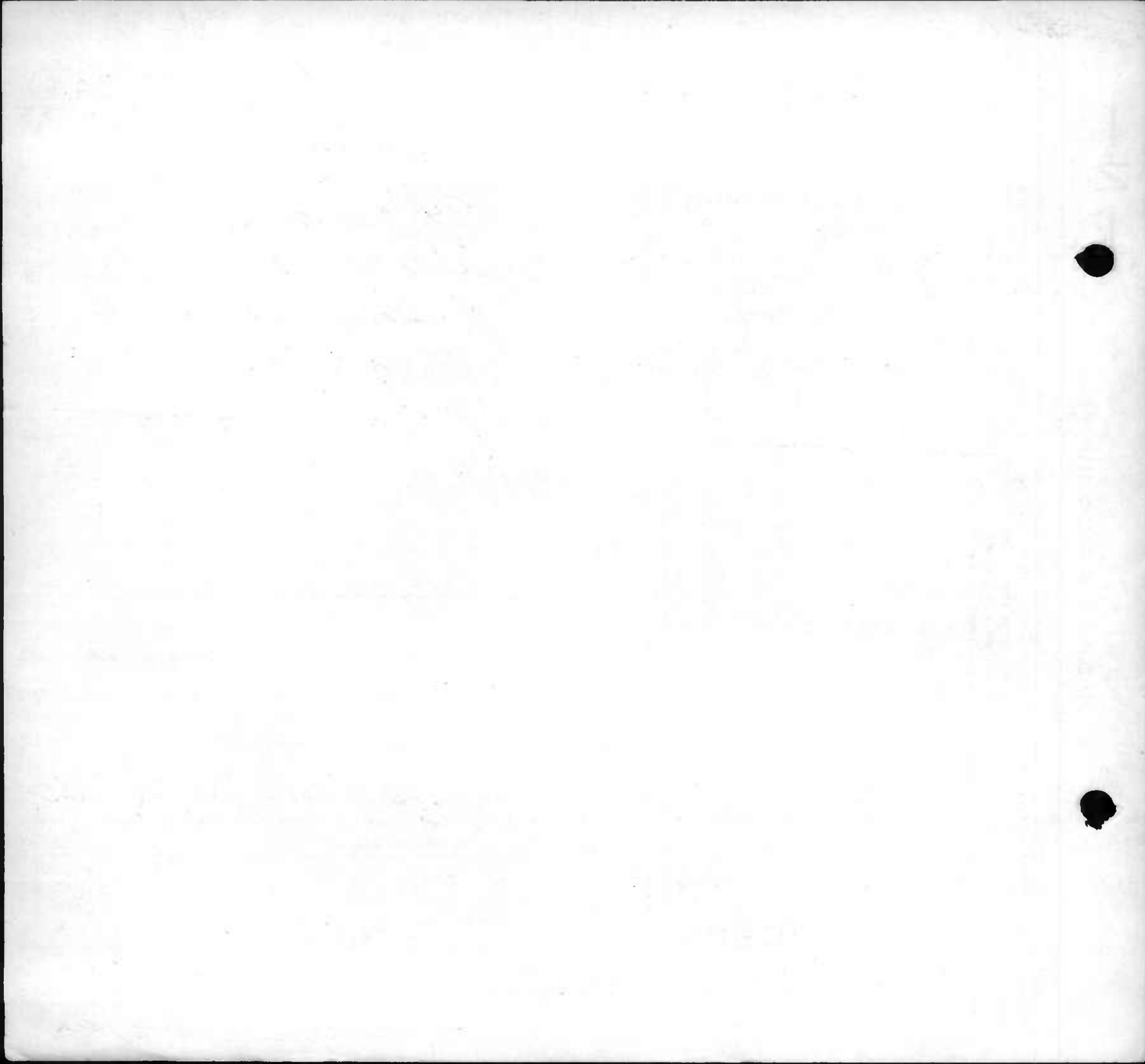
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 68-1479	
BIRTH NO. 68-1479		CERTIFICATE OF DEATH		68-1479	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARSHALL S. FORREST		2. DATE AND HOUR OF DEATH 2/5/68 10:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. AGE (In years last birthday) 71	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 425 SINAI HOSPITAL of BALTIMORE		A. STATE MARYLAND, BALTIMORE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
		D. STREET ADDRESS (If rural, give location) 3825 FAIRVIEW AVE		15-69	
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 12/30/196	9. AGE (In years last birthday) 71	10. If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY American Iron & Smelting Co.		11. BIRTHPLACE (State or foreign country) Saint Mary's CO MARYLAND	
13. FATHER'S NAME George Forrest		14. MOTHER'S MAIDEN NAME Mary - ? ? ?		12. CITIZEN OF WHAT COUNTRY? U.S.A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War 1		16. SOCIAL SECURITY NO. 212-10-1879-A		17. INFORMANT Mrs. Bessie Womack-4129 Fairview Ave.	
18. 427.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) PLEURAL EFFUSION		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) CHRONIC CONG. HEART FAILURE			
		(C) CHRONIC CONG. HEART FAILURE			
434.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		R/O Hepatomegaly Metastatic Effusion C. V. A. involving L & R			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from FEB 1 1968 to FEB 5 1968, that (I) (we) last saw the deceased alive on FEB 5 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph Kimber M.D.				23B. DATE SIGNED 2/5/68	
23C. PHYSICIAN'S NAME (Type) JOSEPH KIMBER M.D.				23D. ADDRESS SINAI HOSPITAL of BALTIMORE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/9/68		24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery	
				24D. LOCATION (City, town, or county) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. FEB 7 1968		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS Herbert E. Nutter-3035 W. North Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1480	
68-1480				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Sarah Young		Feb 1 1968 3 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
940 N. Broadway				Maryland Baltimore	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER					
940 N. Broadway					
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Female		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Feb 17 1897	70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		none		Baltimore Md	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Charles A. Whelan		Mary Ellis		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no				James J. Jones	
18. 162.1 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		3	
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		Carcinoma of lung			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
163X II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 27 1968 to Feb. 1 1968, that (I) (we) last saw the deceased alive on Jan 27 1968 and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
F. K. Adams				12-2-68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
F. K. ADAMS				1222 N. Caroline St	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		2-5-68		Mt. Hope	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
FEB 7 1968		Robert E. Taylor		Chapman 1000 Cranberry Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				68-1481		REG. NO. 68-1481	
BIRTH NO. 68-1481				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Lee, Leon</u>				2. DATE AND HOUR OF DEATH <u>February 2, 1968</u> <u>12:45 p. m.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>20-07</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2324 Caton Avenue</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10/1/89</u>		9. AGE (In years last birthday) <u>78</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Stephen W. Lee</u>				14. MOTHER'S MAIDEN NAME <u>Ellen P. Lee</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hugo Lee 1304 Myrtle Ave</u>		ADDRESS	
18. <u>431.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>CEREBRAL HEMORRHAGE</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ARTERIOSCLEROSIS - GENERALIZED</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>SENILITY</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <u>5</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>January 31, 1968</u> 19 to <u>February 2, 1968</u> , that (I) (we) last saw the deceased alive on <u>February 2, 1968</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>G. L. Banfield</u>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>2/3/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>G. L. BANFIELD, M.D.</u>				23D. ADDRESS <u>722 N. FULTON AVE, BALTIMORE, MD.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>2-7-68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mount Auburn</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 7 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. ...</u>		25C. FUNERAL DIRECTOR <u>Raymond ...</u>		ADDRESS	

68- 1482

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 1482

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ISSAAC WALKER				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 1 Day 28 Year 68 Hour 7:30 a.m.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2208 Henneman Ave.				3. DATE PRONOUNCED DEAD Month January Day 28 Year 1968 Hour 8-04			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY							
6. SEX Male	7. RACE Colored	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH Sept 25-1918		10. AGE (In years last birthday) 48		E. STREET AND NUMBER 2208 Henneman Ave.			
11. BIRTHPLACE (State or foreign country) Va		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Philip Walker			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MARDEN NAME Mary Good			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.		18. INFORMANT Pearl Hardwell			
19. 442X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Rupture of aneurysm into bronchus ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) YES	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Edward F. Wilson, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED January 28, 1968							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-31-68		24C. NAME of CEMETERY or CREMATORY Summit VA		24D. LOCATION (City, town, or county) (State) Va	
25A. DATE REC'D BY HEALTH DEPT. FEB 7 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR ADDRESS Paul Paul Samell, VA Elroy Oshon NW Sumner			

[Faint, illegible handwriting]

WALLEY FORD

25/10/1911

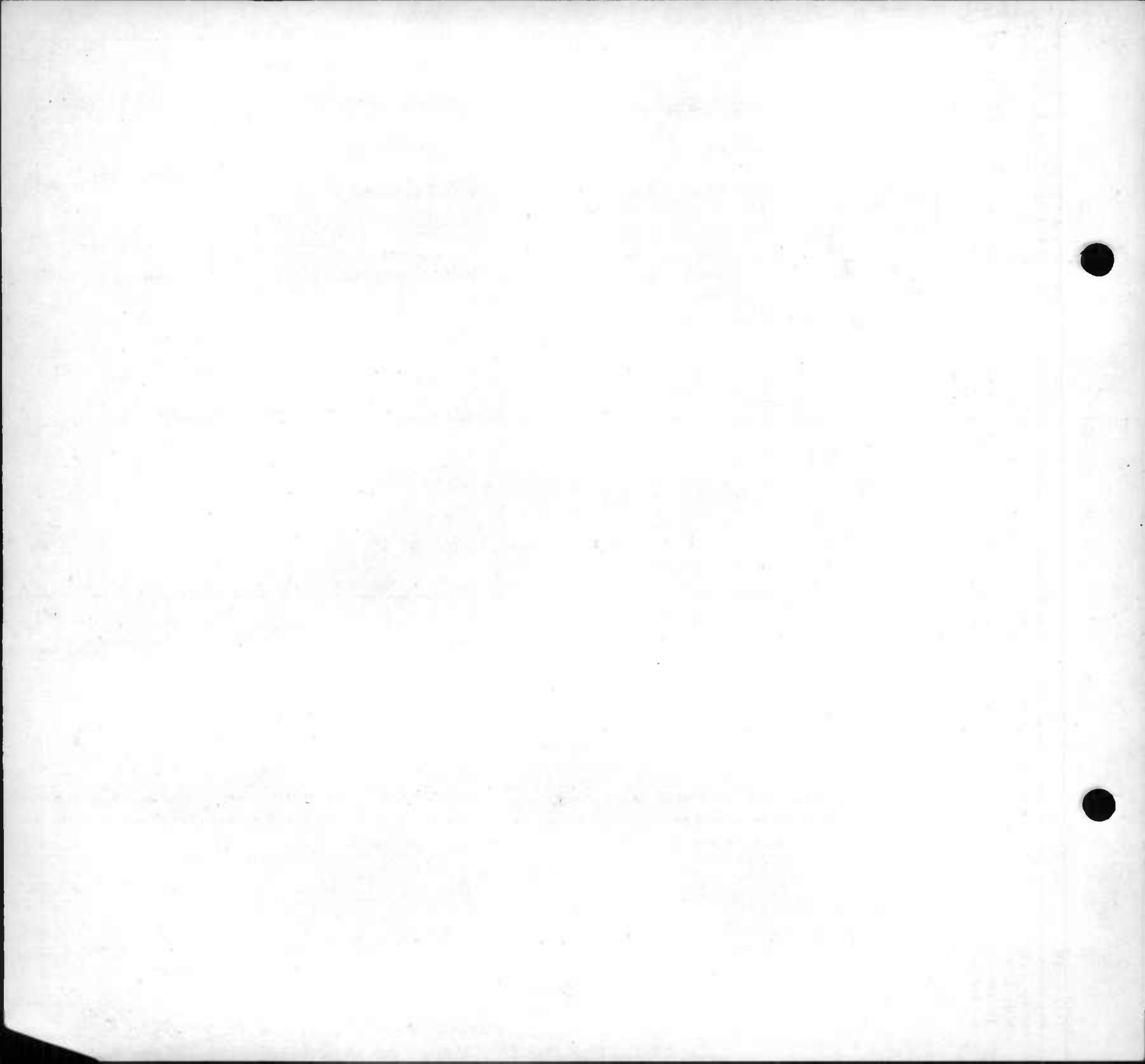
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 967 68-1483

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JONES, JOHN B.		2/5/68 4:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Bolton Hill Nursing & Convalescent Ctr.				A. STATE Maryland	
				B. COUNTY	
C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 945 Bennett Place					
5. SEX M	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/7/95	9. AGE (In years last birthday) 72
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Belmont				Maryland	
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes		16. SOCIAL SECURITY NO. 218-07-0866A		17. INFORMANT Dorine Rawlings Senior	
18. 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE cerebral vascular accident DUE TO, OR AS A CONSEQUENCE OF: new and old. (B) generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) diabetes		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/15 19 67 to 2/5 19 68, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Allan Macht				23B. DATE SIGNED 2/5/68	
23C. PHYSICIAN'S NAME (Type) Allan Macht				23D. ADDRESS 2 E Pearl St Balt - Md	
24A. BURIAL CREMATION, REMOVAL (Specify) 2-8-68 Burial		24B. DATE 2-8-68		24C. NAME OF CEMETERY or CREMATORY Baltimore Nat Cem	
24D. LOCATION (City, town or county) (State) Baltimore		24E. DATE REC'D BY HEALTH DEPT. FEB 7 1968		24F. NAME OF REGISTRAR John E. Smith	
24G. FUNERAL DIRECTOR Chapman		24H. ADDRESS 1000 Broadway St			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1484

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 1484

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

IDA RICHARDSON

2. DATE AND HOUR OF DEATH

5 FEB 68

2 50 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hoag.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTO

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

719 W FAYETTE ST.

5. SEX

F

6. RACE

N

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

2-20-83

9. AGE (In years
last birthday)

76

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

UNKNOWN

11. BIRTHPLACE (State or foreign country)

USA

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

214-56-9934

17. INFORMANT

PATIENT'S CHART

ADDRESS

18. 412.9 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

CARDIAC ARREST

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

25 MIN

(B) CORONARY ATHEROSCLEROSIS

DUE TO, OR AS A CONSEQUENCE OF:

UNKNOWN

(C) BRONCHOPNEUMONIA

UNKNOWN

MEDICAL CERTIFICATION

420.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

Dehydration

19A. DATE OF OPERATION
NONE19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

N/A

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

N/A

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

N/A

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

N/A

21D. TIME
OF INJURY
(APPROX.)

N/A

21E. INJURY OCCURRED

White At ☐
WorkNot White At ☐
Work

21F. HOW DID INJURY OCCUR?

N/A

22. I certify that (I) (this hospital) attended the deceased from 4 FEB 68 19 to 5 FEB 19 68,
that (I) (we) lost saw the deceased alive on 5 FEB 19 68 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Timothy K. Gray MD

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

5 FEB 68

23C. PHYSICIAN'S
NAME (Type)

TIMOTHY K. GRAY MD

DEGREE

23D. ADDRESS

UNIV. OF MARYLAND HOSPITAL

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

2-26-68

24C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cem

24D. LOCATION

(City, town, or county)

(State)

Baltimore

25A. DATE REC'D BY HEALTH DEPT.

FEB 7 1968

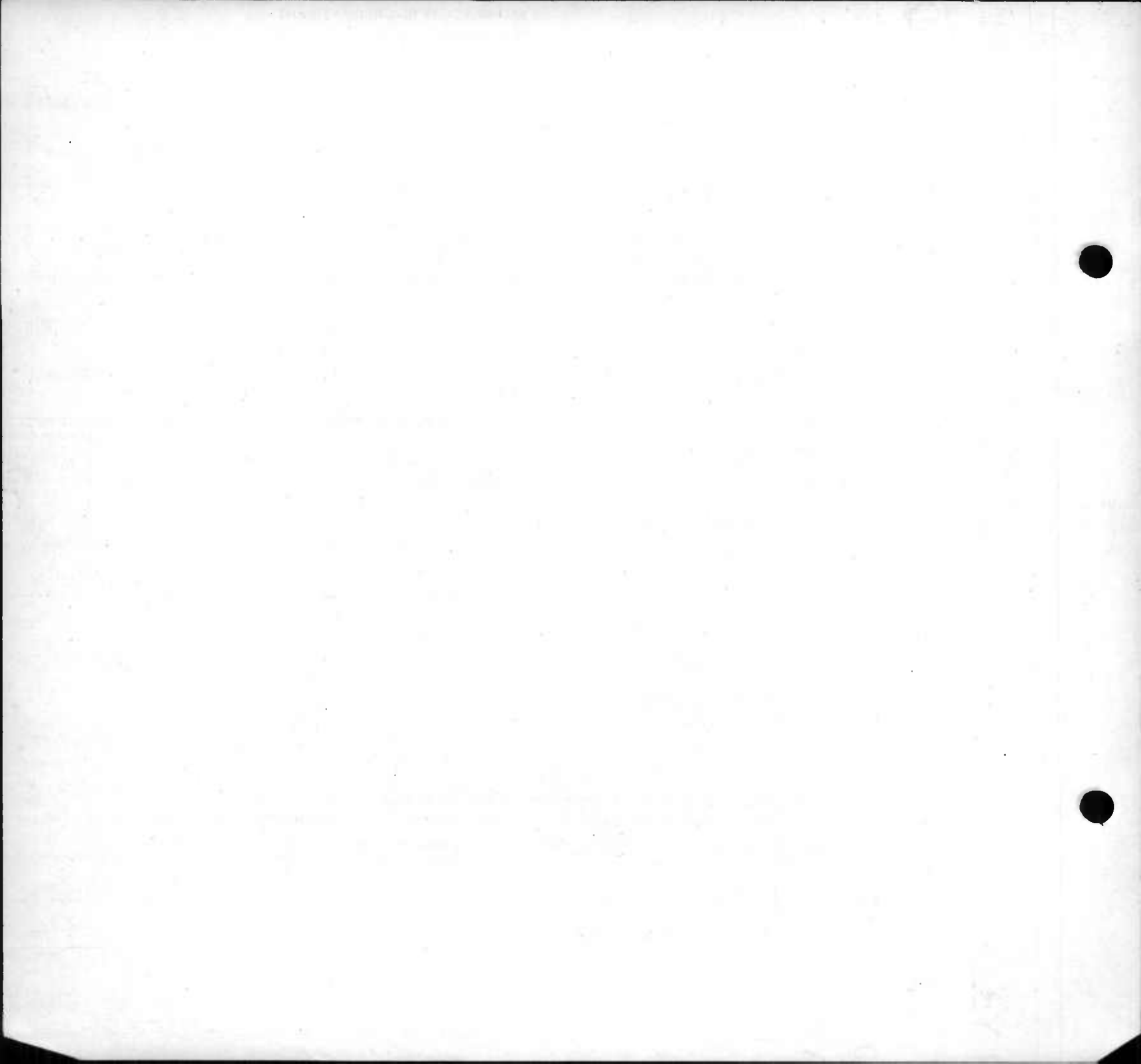
25B. NAME OF REGISTRAR

J. E. Taylor

25C. FUNERAL DIRECTOR

Shay Wilson on Brantley

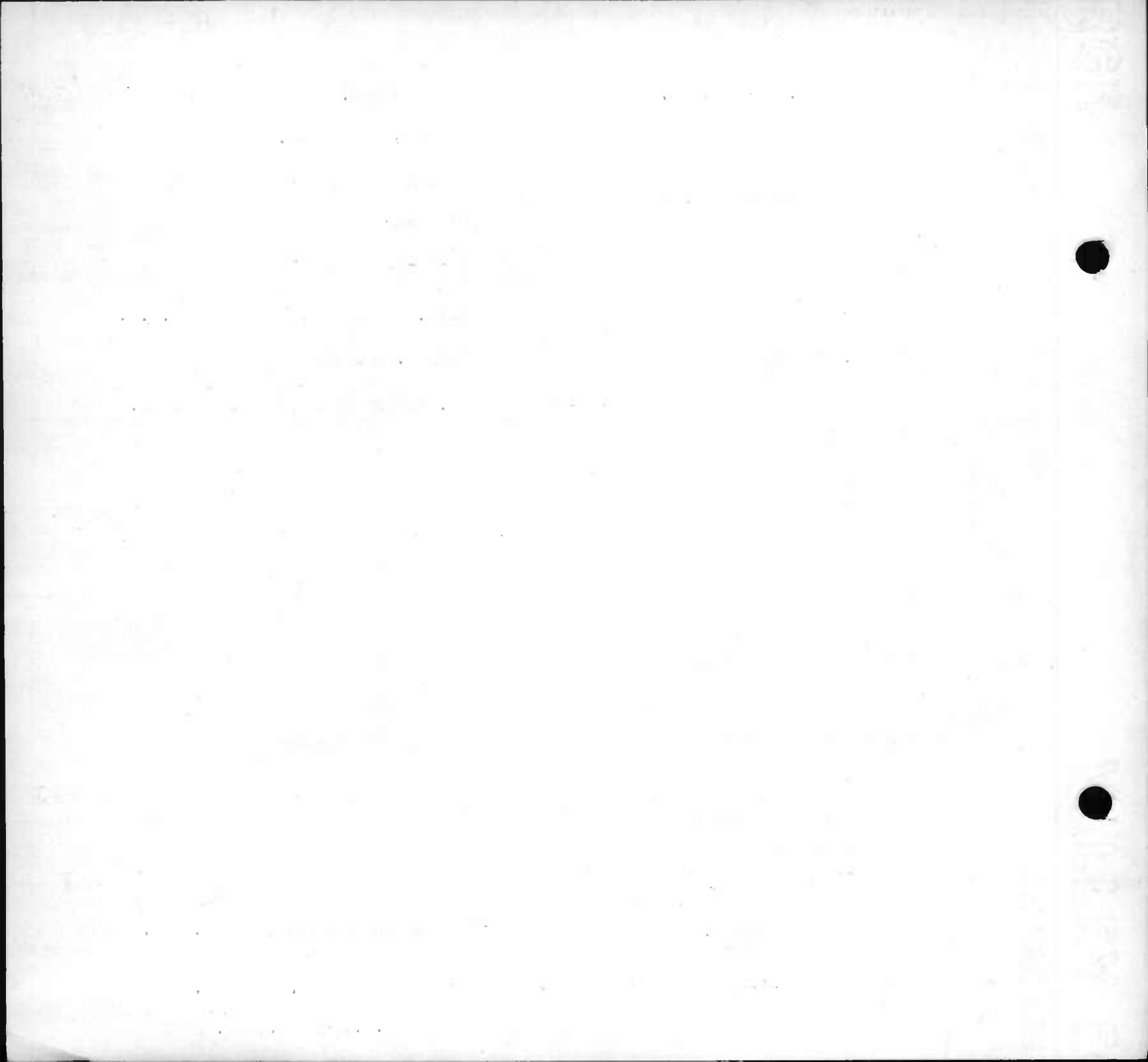
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 1485	
68- 1485				CERTIFICATE OF DEATH	
BIRTH NO.			1. NAME OF DECEASED (Type or Print)		
			Alden L. Holden, Sr.		
2. DATE AND HOUR OF DEATH			Feb. 6, 1968 7:00 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 00 3627 Galston Drive			A. STATE B. COUNTY Maryland Balto.		
C. CITY OR TOWN			D. INSIDE CITY LIMITS?		
Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER			3627 Galston Drive		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12-20-02	65	Retired
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
			Balto.		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Alden L. Holden			Mary E. Holden		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
no			214-03-3055A		3627 Galston Drive Mrs. Alden Holden, Baltimore, Md. 21229
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Carcinomatosis		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Carcinoma of lung -		
			(C)		
163X II			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			3 mo.		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			No		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-20-1966 to 2-6-1968, that (I) (we) last saw the deceased alive on 2-5-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Harry L. Knipp, M.D.				2-7-68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Harry L. Knipp, M.D.				4116 Edmondson Avenue, Balto., Md. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		2-9-68		Lorraine Park Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
FEB 7 1968		Robert E. Johnson		4101 Edmondson Avenue Witzke F.D., Balto., Md. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5R 5216

68- 1486

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 1486

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Bessie A. Romoser		2. DATE AND HOUR OF DEATH 2-6-68 4 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balto.		1903	
FULL NAME OF HOSPITAL OR INSTITUTION 00 1330 W. Lombard Street		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1330 W. Lombard St.			
5. SEX Female	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-19-1888	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto., Md.	
13. FATHER'S NAME --- Grimm		14. MOTHER'S MAIDEN NAME --- Grimm		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ACUTE CORONARY THROMBOSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIOSCLEROTIC C.V. DISEASE 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 15 yrs 4 days		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLEROTIC C.V. DISEASE (B) DUE TO, OR AS A CONSEQUENCE OF: VIRAL PNEUMONITIS (C) 1 hr		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 26 19 68 to FEB 6 19 68 , that (I) (we) last saw the deceased alive on FEB 6 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Norman R. Kleiman				23B. DATE SIGNED 2/7/68	
23C. PHYSICIAN'S NAME (Type) Norman Kleiman				23D. ADDRESS 3803 Edmondson Avenue, Balto. Md. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-9-68		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION Balto.		24E. Md.		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. FEB 7 1968		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR ADDRESS Witzke Funeral Directors, Balto., Md. 21229	

Agent General Insurance

State of Wisconsin

Wm. A. Waterbury

1882 FEB 1

1882

James K. ...

68- 1487

BALTIMORE CITY HEALTH DEPARTMENT

68- 1487

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CARROLL W. JAMES		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour February 5, 1968 8:30 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour February 5, 1968 8:30 A.M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 3-27-05		10. AGE (In years lost birthday) 62	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 213-10-0229	
15. MOTHER'S MAIDEN NAME Catherine Schaeffe		18. INFORMANT Mrs. Carroll James, Baltimore, Md. 21228	
19. 412.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2/5/68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-8-68	
24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. FEB 7 1968		25B. NAME OF REGISTRAR Robert E. Spitz, M.D.	
25C. FUNERAL DIRECTOR Witzke Funeral Directors, Balto., Md. 21229		ADDRESS 4101 Edmondson Avenue	

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

68-- 1488

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-- 1488

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN W. DETTS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year February 3, 1968 3:35 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 639 Pitcher Street (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour February 3, 1968 3:35 P. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 10/2/88		10. AGE (In years lost birthday) 79	
11. BIRTHPLACE (State or foreign country) Reisterstown Md		12. CITIZEN OF WHAT COUNTRY? U S A	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) Yes W W I	
17. SOCIAL SECURITY NO. 220-02-1178		18. INFORMANT ADDRESS Mrs Gladys Alexander, same	
19. 412.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/8/68	
24C. NAME OF CEMETERY or CREMATORY National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. FEB 8 1968		25B. NAME OF REGISTRAR Robert E. Faldut	
25C. FUNERAL DIRECTOR A Halstead		25D. ADDRESS 1206 W North Ave	

THE STATE OF TEXAS, COUNTY OF DALLAS, ss. I, the undersigned, a Notary Public in and for the State of Texas, do hereby certify that the within and foregoing is a true and correct copy of the original of the same as the same appears from the records of the County of Dallas, State of Texas.

WALTER H. POOL

NOTARY PUBLIC

My Comm. Expires 10-1-00
Notary Public in and for the State of Texas

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1489

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

REG. NO.

68-1489

BIRTH NO.

1. NAME OF DECEASED

BETTINELLI, JOSEPH

2. DATE AND HOUR OF DEATH

3-5-68 6:10 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

*33
Johns Hopkins Hospital*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE *Maryland*

B. COUNTY *Baltimore*

C. CITY OR TOWN

E. STREET AND NUMBER *905 Fawn St.*

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

5. SEX *M*

6. RACE *W*

7. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH *3-19-97*

9. AGE (In years last birthday) *70*

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LABOR

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) *ITALY*

12. CITIZEN OF WHAT COUNTRY? *ITALY*

13. FATHER'S NAME

ANGELO BETTINELLI

14. MOTHER'S MAIDEN NAME

OLIVIA ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

217-48-1039

17. INFORMANT

ADDRESS

MRS. MINNIE BETTINELLI 905 FAWN ST.

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

Myocardial Infarction

(B) DUE TO, OR AS A CONSEQUENCE OF:

Atherosclerotic heart disease

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

7 days

10-15 yrs

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

GI bleeding, pneumonia, CHF

7 days

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from *1/28/68* 19 *68* to *2/5/68* 19 *68*, that (1) (we) lost saw the deceased alive on *6:10 PM 1/28* 19 *68* and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Allen B. Kaver

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

2/5/68

23C. PHYSICIAN'S NAME (Type)

Allen B. Kaver, MD

DEGREE

23D. ADDRESS

JHH

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

2/8/68

24C. NAME OF CEMETERY or CREMATORY

HOLY REDEEMER

24D. LOCATION

BALTO. Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

FEB 7 1968

Allen B. Kaver

Frank DellaNoce 322 S. High

29 13-81-2

FUNERAL DIRECTOR: IMPORTANT

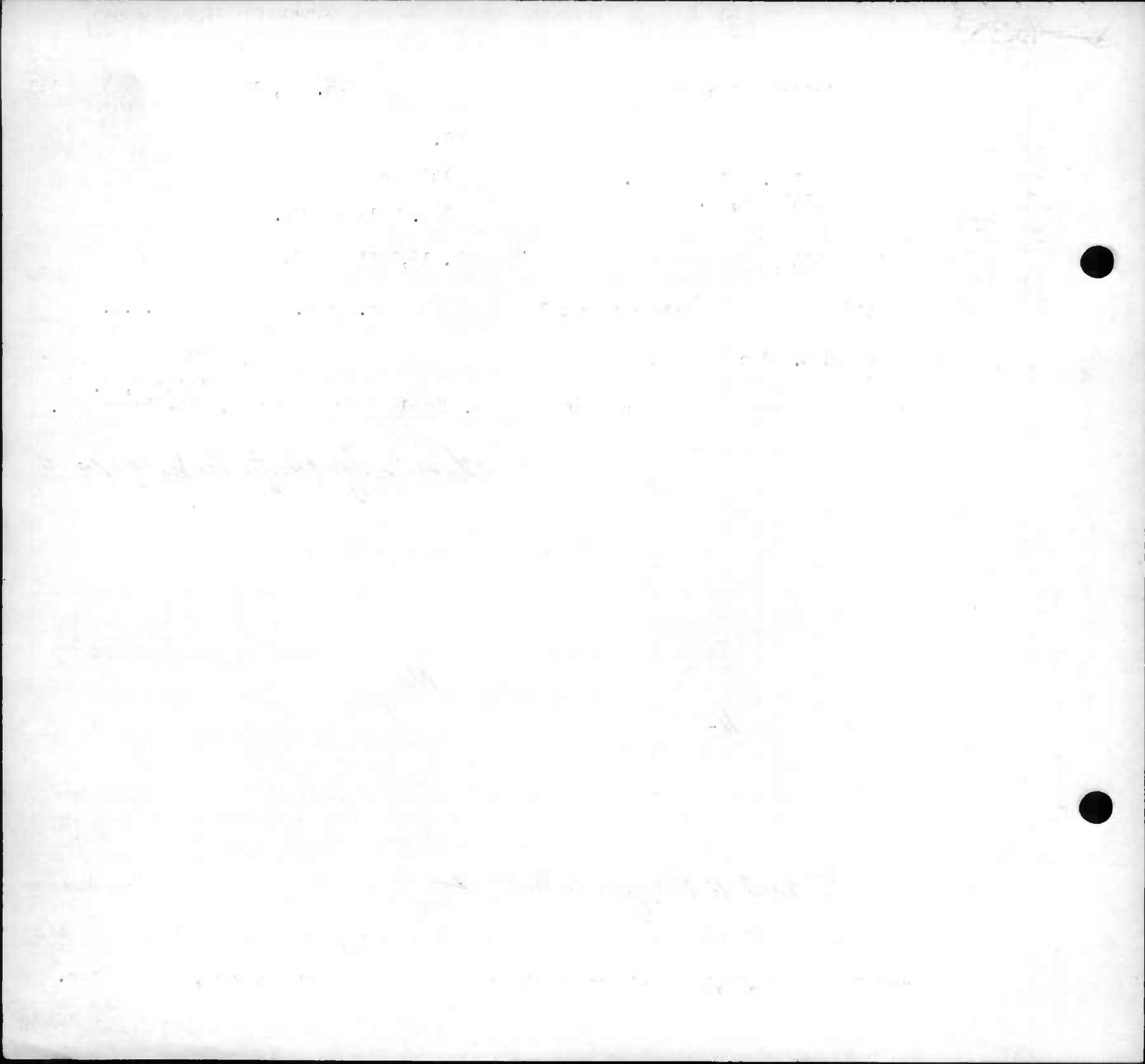
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1490

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 1490

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Winifred Black Jordan		Jan. 29, 1968 1:30	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
70 1 W. Melrose Ave. Baltimore, Md.				Md.	
C. CITY OR TOWN				D. INSIDE CITY LIMITS?	
Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER					
701 W. Melrose Ave.					
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	Feb. 16, 1911	56	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired		McDonogh School		Aetna Co. Tenn.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Robert S. Black			Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		None		Baltimore, Md.	
		unknown		Dr. Charles Edward Jordan, 701 Melrose Ave.	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
204.1 I				Chronic lymphatic leukemia 4 years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
204.0 II				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
No					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Paul H. Royse M.D.				1-30-68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
PAUL H. ROYSE MD				1403 FOLEY LANE PIKESVILLE, MD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		Jan. 31, 1968		Mimosa Cemetery	
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
Jan 31 1968		Frank H. Newell, Pikesville, Md.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

68-1491 **CERTIFICATE OF DEATH** Registered No. 68-1491

BIRTH NO. **M.E. CASE NO.**

1. NAME OF DECEASED (Type or Print) **Mary Warvel** 2. DATE AND HOUR OF DEATH **January 25, 1968** **12:45 P.M.**

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **Keswick Home for Incurables**
700 W. 40th Street
Baltimore, Maryland 21211

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE **Maryland** B. COUNTY **Baltimore County** **53-00**

C. CITY OR TOWN (If outside city limits, write RURAL and give township) **PIKESVILLE, MD**

D. STREET ADDRESS (If rural, give location) **12 BRIGHTSIDE AVE.**

5. SEX **Female** 6. RACE **White** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) **widow** 8. DATE OF BIRTH **8-24-1887** 9. AGE (In years last birthday) **81 years**

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **practical nurse** 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) **Carroll County, Md.** 12. CITIZEN OF WHAT COUNTRY? **United States**

13. FATHER'S NAME **Howard W. Barnhart** 14. MOTHER'S MAIDEN NAME **Laura Reaver**

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) **no** 16. SOCIAL SECURITY NO. **217-22-8850A** 17. INFORMANT **Mary B. Di Paula, R.N.** ADDRESS **Keswick Home**

18. **486X I** CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A) **Pneumonia &** **Days**

(B) **Gastrointestinal bleeding** **Days**

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

493X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. **ASCVD = Parkinsonism** **Years**

19A. DATE OF OPERATION **6** 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from **May 1958** to **Jan 23 1968**, that (I) (we) last saw the deceased alive on **Jan 24 1968** and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

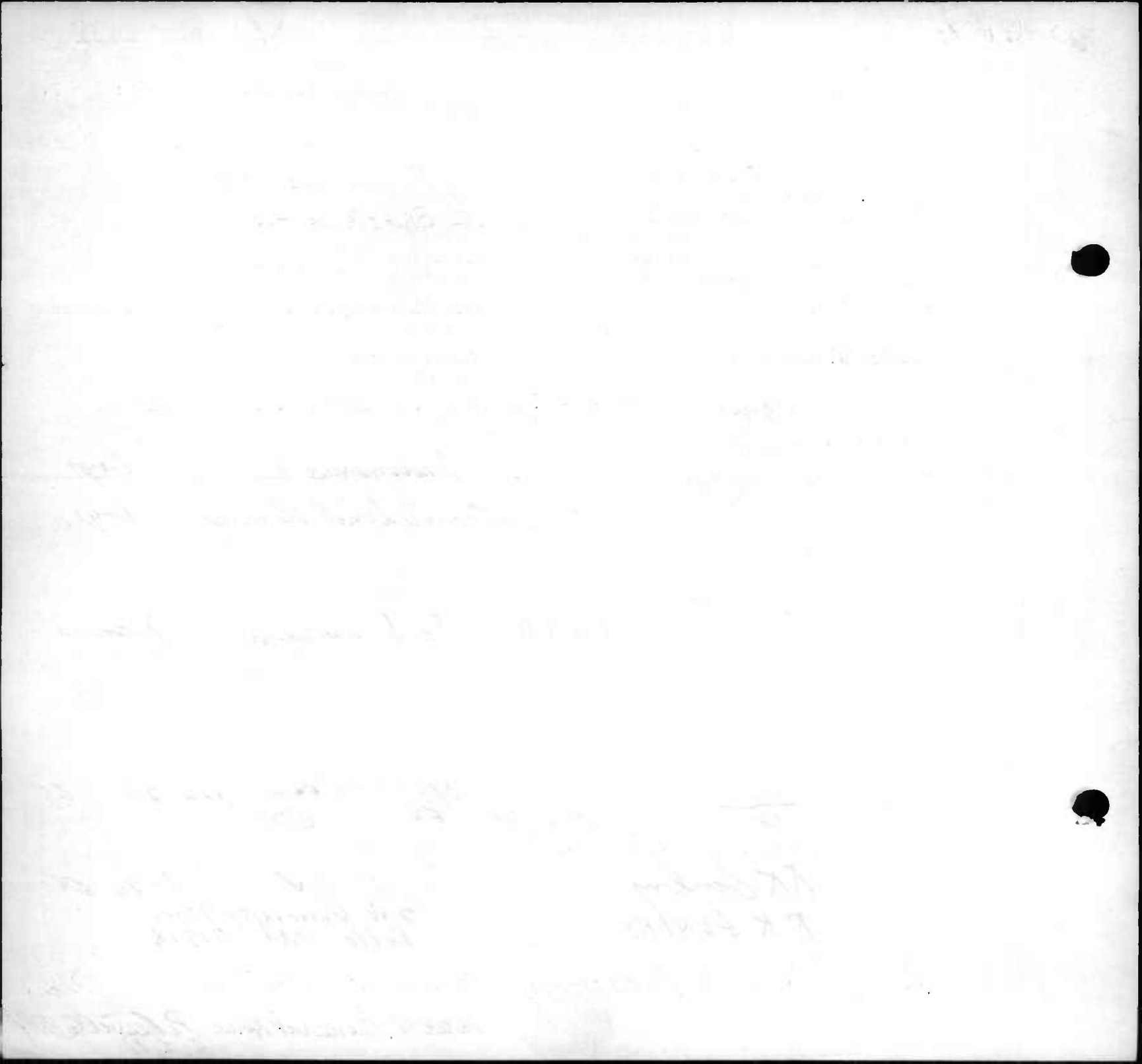
23A. SIGNATURE **RK Gundry** M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED **1-26-68**

23C. PHYSICIAN'S NAME (Type) **R K GUNDY** M.D. 23D. ADDRESS **2 W University Pkwy**
Balto Md 21218

24A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **Jan 27, 1968** 24C. NAME OF CEMETERY or CREMATORY **Meadowridge Memorial Park** 24D. LOCATION (City, town, or county) (State) **Baltimore, Md.**

25A. DATE REC'D BY HEALTH DEPT. **FEB 7 1968** 25B. NAME OF REGISTRAR **Robert S. Johnson** 25C. FUNERAL DIRECTOR **Revel Funeral Home** ADDRESS **Pikesville Md**
D. L. 97

VS 150-REV. 1/1/65



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1492

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 1492

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Anthony B SERGI		2. DATE AND HOUR OF DEATH DOA 2/4/68 7:17P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTIMORE		5. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 422 SINAI' HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 107 Waldron Ave	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/29/05	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GAS-STATION		10B. KIND OF BUSINESS OR INDUSTRY TEXACO, CO.		11. BIRTHPLACE (State or foreign country) PHILADELPHIA	
13. FATHER'S NAME ANTHONY SERGI, SR.		14. MOTHER'S MAIDEN NAME MARIA FIDDI		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 220-05-8598		17. INFORMANT Mrs. Ruth Sergi, 107 Waldron Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 412.9 I Cerebral hemorrhage ASCVD		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from DOA 19 1968 to 1968 , and that (I) (we) lost saw the deceased alive on DOA 19 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Allen S. Glushko		23B. DATE SIGNED 2/4/68		23C. PHYSICIAN'S NAME (Type) Allen S. Glushko	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Feb. 9, 1968		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Center	
24D. LOCATION (City, town, or county) (State) Baltimore, MD.		25A. DATE REC'D BY HEALTH DEPT. FEB 7 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Frank H. Newell		25D. ADDRESS Pikesville, MD.		25E. ADDRESS Pikesville, MD.	

10/27/75

10/27/75

X

W

Central Highway

A 2500

W

W

10/27/75

10/27/75

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-1493	
BIRTH NO. 68-1493		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) O'NEAL MR HIRAM		2. DATE AND HOUR OF DEATH 31 st Jan 1968 1-40 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 CHURCH HOME AND HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-18 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5210 LINDEN HGTS AVE			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-27-98	9. AGE (In years last birthday) 69	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUTO MECH		10B. KIND OF BUSINESS OR INDUSTRY PENNY BROTHERS		11. BIRTHPLACE (State or foreign country) SEVERN, MD.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes N. VI		16. SOCIAL SECURITY NO. 213-10-7404		17. INFORMANT ADDRESS MRS. Mildred O'NEAL, 5210 LINDEN HGT. BALTIMORE 15 MD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) 163X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma lungs Diffuse metastasis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 1-28-1968 to 31 st Jan 1968, that (X) (we) last saw the deceased alive on 1-31-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rodelio M. Lim				23B. DATE SIGNED 1-31-68	
23C. PHYSICIAN'S NAME (Type) Rodelio M. Lim				23D. ADDRESS CHH	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE FEB. 3, 1968		24C. NAME OF CEMETERY OR CREMATORY WESLEY METHODIST CEMETERY	
24D. LOCATION (City, town, or county) Hampstead, Md.		24E. NAME OF REGISTRAR		24F. FUNERAL DIRECTOR	
25A. DATE REC'D BY HEALTH DEPT. FEB 7 1968		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	

4-10-68

2300 LINDEN AVE
1-22-68

PA

UNKNOWN

Concrete Lungs
Diffuse metastasis

12 Jan 68

1-22-68

WALSH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) KATHERINE MILLER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 1 27 68 12:35p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 99 Union Memorial Hospital D.O.A. (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour January 27, 1968 12:35 p.m.	
6. SEX Female		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH June 3, 1925		10. AGE (In years lost birthday) 42	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY own home	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 212-40-5741	
18. INFORMANT Mr. Edward Miller, 3101 Northwind Rd.		ADDRESS Baltimore, Md.	
19. CAUSE OF DEATH E 730.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. E 95.4X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE Syncope during anesthesia for dental surgery DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Dentist's office	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) Before 12:45 p.m. on 1/27/68		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Dr. O'Connell's Office 11-02		22F. HOW DID INJURY OCCUR? Therapeutic misadventure	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED January 28, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Feb. 1, 1968	
24C. NAME OF CEMETERY or CREMATORY David Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville 8, Md.	
25A. DATE REC'D BY HEALTH DEPT. FEB 7 1968		25B. NAME OF REGISTRAR R. E. Johnson	
25C. FUNERAL DIRECTOR D. J. Russell		ADDRESS Pikesville 8, Md.	

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

68-1495

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-1495

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EVELYN S. PUMPHREY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> February 5, 1968 Hour 1:30 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1802 W. Baltimore St. (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour February 5, 1968 4:05 P. M.	
6. SEX female		7. RACE negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
9. DATE OF BIRTH 2/10/14		10. AGE (In years lost birthday) 53 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) John Smith		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
13. FATHER'S NAME John Smith		15. MOTHER'S MAIDEN NAME Sadir	
18. INFORMANT James Pumphrey		ADDRESS 1802 W. Baltimore, 3	
19. 1621 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Lung (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) No	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2/6/68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/9/68	
24C. NAME OF CEMETERY or CREMATORY Baltimore, National		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. FEB 7 1968		25B. NAME OF REGISTRAR Charles A. Rice	
25C. FUNERAL DIRECTOR Charles A. Rice		ADDRESS 661 W. Barre St.	

2/10/14

55

John Smith

U.S.A.

John Smith

Sedle

James Humphrey 1802 W. Baltimore

Caroline of Long

Serial

2/9/88

Baltimore, National

Baltimore, Maryland

Charles A. Lee 661 E. Baltimore

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 1496

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LEONARD M. JOHNSON				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> February 4, 1968 2:45 A. M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 739 W. Fairmount Avenue				3. DATE PRONOUNCED DEAD Month Day Year Hour February 4, 1968 2:45 A. M.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 4-02				C. CITY OR TOWN Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. SEX Male		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 739 W. Fairmount Avenue	
9. DATE OF BIRTH 11/17/38		10. AGE (in years birthday) 29		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		13. FATHER'S NAME JAMES JOHNSON	
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.		15. MOTHER'S MAIDEN NAME MARIE SUTTON	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14B. KIND OF BUSINESS OR INDUSTRY		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 216-36-4010	
17. SOCIAL SECURITY NO. XXXXXX-XX-XX				18. INFORMANT ADDRESS Bernice Beal 739 W. Fairmount Ave.			
19. I E-966X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II E-927X OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH Stab wound of chest, left (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 2 4 1968 2:25 A.				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 739 W. Fairmount Avenue				22F. HOW DID INJURY OCCUR? Stabbing			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2-4-68							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/8/68		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Baltimore		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. FEB 6 1968		25B. NAME OF REGISTRAR Paul E. Ferguson		25C. FUNERAL DIRECTOR ADDRESS Charles A. Rice 661 W. Barre St.			

A.D.

11/11/38
RECEIVED

JAMES JOHNSON

U.S.A.

MARYL RD

MARIE SUTTON

216-26-4010 (XXXXXXXXXX) Betrice Road 739 W. Baltimore Ave.

WATKINS & PUGH

11/11/38

Baltimore, Maryland

WATKINS & PUGH

2/8/38

Partial

Charles A. Rice 681 W. Baltimore Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 1497 CERTIFICATE OF DEATH

REG. NO. 68- 1497

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ALICE ROSETTA SAVAGE		2. DATE AND HOUR OF DEATH <i>Feb 6, 1968 8:30 P M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 25-33		C. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 2601 Ridgely Street		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 12/25/87		9. AGE (In years last birthday) 80		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Rubin Johnson	
14. MOTHER'S MAIDEN NAME Mary Robinson		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Family		ADDRESS		18. 403X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Chemia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Nephrosclerosis Generalized Arteriosclerosis	
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Feb 1</i> 19 <i>68</i> to <i>Feb 6</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Feb 3</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Ricardo Lozada</i>				23B. DATE SIGNED <i>2/6/68</i>	
23C. PHYSICIAN'S NAME (Type) RICARDO LOZADA				23D. ADDRESS <i>1228 S. Charles St. Bk. Md 21230</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/10/68		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. <i>FEB 7 1968</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR Charles A. Rice 661 W. Barre St.			

1000 N. 1st St.

W 12 / 25 / 87

Virginia

Harry Robinson

Family

1000 N. 1st St.

Harry Robinson

68- 1498

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 1498

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ANNIE THOMAS

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

1

31

68

10:43 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

755 W. Lexington St.

3. DATE

Month

Day

Year

Hour

PRONOUNCED DEAD

January

31,

1968

10:43 a.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Female

7. RACE

Colored

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

12/15/87

10. AGE (In years
lost birthday)

80

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

755 W. Lexington St.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Thomas

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Ida Hebron

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, near unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Wm. Thomas 811 Pierce St.

19. 412.9 I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Arteriosclerotic Cardiovascular Disease

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

422.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

22F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

January 31, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

2/3/68

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial

Queen

Queen Chapel

Murrkirk, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

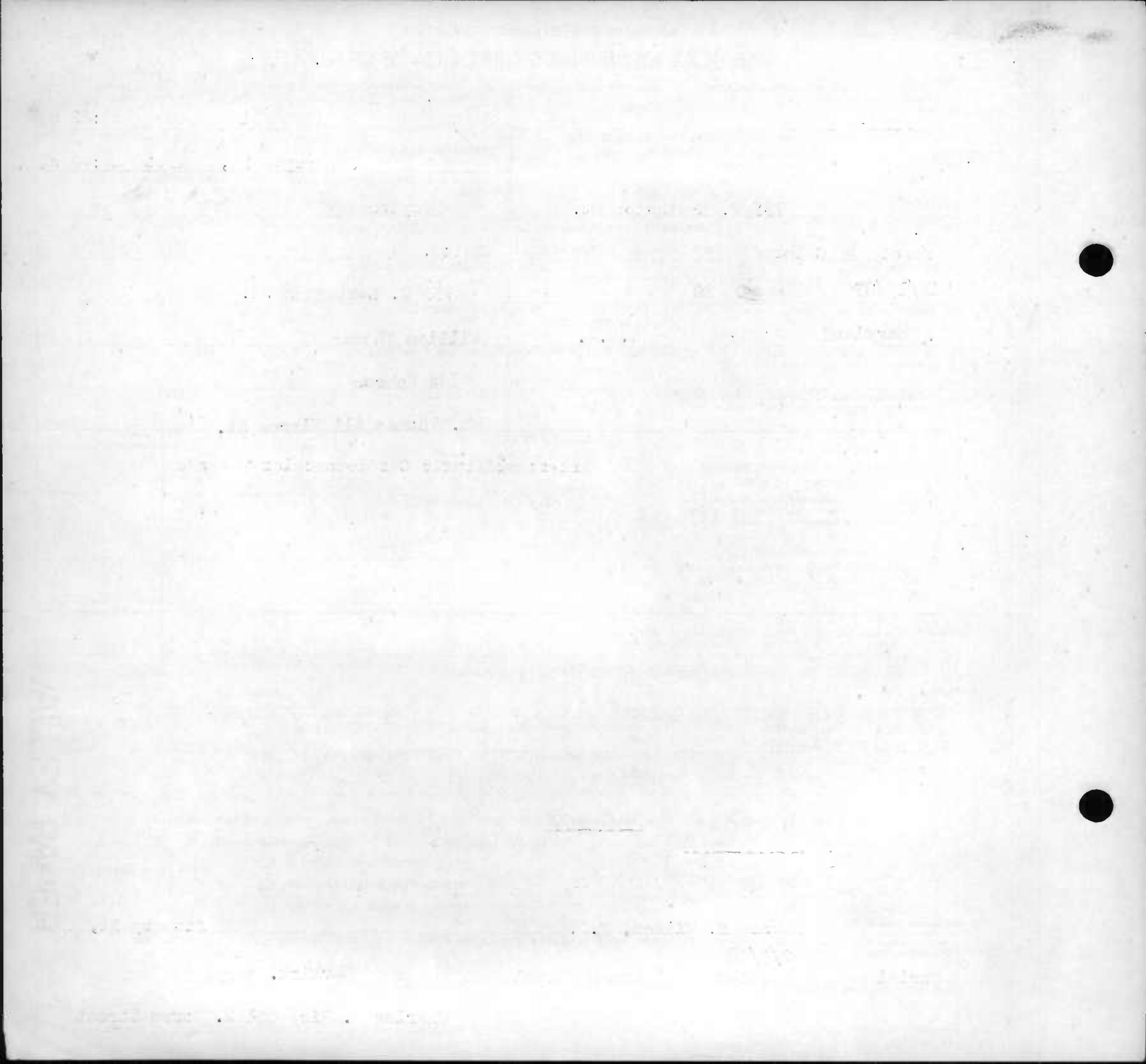
25C. FUNERAL DIRECTOR

ADDRESS

Feb 7 1968

Robert E. Seaborn

Charles A. Rice 661 W. Barre Street



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 1499

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 1499

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Clarence E Warner

2. DATE AND HOUR OF DEATH

2 Feb 68

7 00

P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University of Maryland Hospital
38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland Baltimore

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

128 Scott Street

5. SEX

MALE

6. RACE

NEGRO

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

1 Apr 09

9. AGE (In years
last birthday)

58

If Under 1 Yr.
Months: Days: Hours: Min.

If Under 24 Hrs.
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

ERNEST WARNER

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Medical Record

18. 796.9 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

Diffuse meningo-encephalopathy
with left chronic subdural
hematoma and cerebral atrophy

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

24

MEDICAL CERTIFICATION

795.5 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

317 Jan 68

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

Subdural Hematoma

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

No

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 10 JAN 68 to 2 Feb 19 68,
that (1) (we) last saw the deceased alive on 2 Feb 19 68 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.

23A. SIGNATURE

William Edward Mock M.D.

Attending
Phys. ☒

Med.
Director ☐

Staff
Phys. ☒

23B. DATE SIGNED

2 Feb 68

23C. PHYSICIAN'S
NAME (Type)

William Edward

Mock M.D.

23D. ADDRESS

University of Md. Hosp Balto Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Buried

24B. DATE

2-8-68

24C. NAME of CEMETERY or CREMATORY

West Calvary Cem

24D. LOCATION

Brooklyn, Md.

(City, town, or county)

(State)

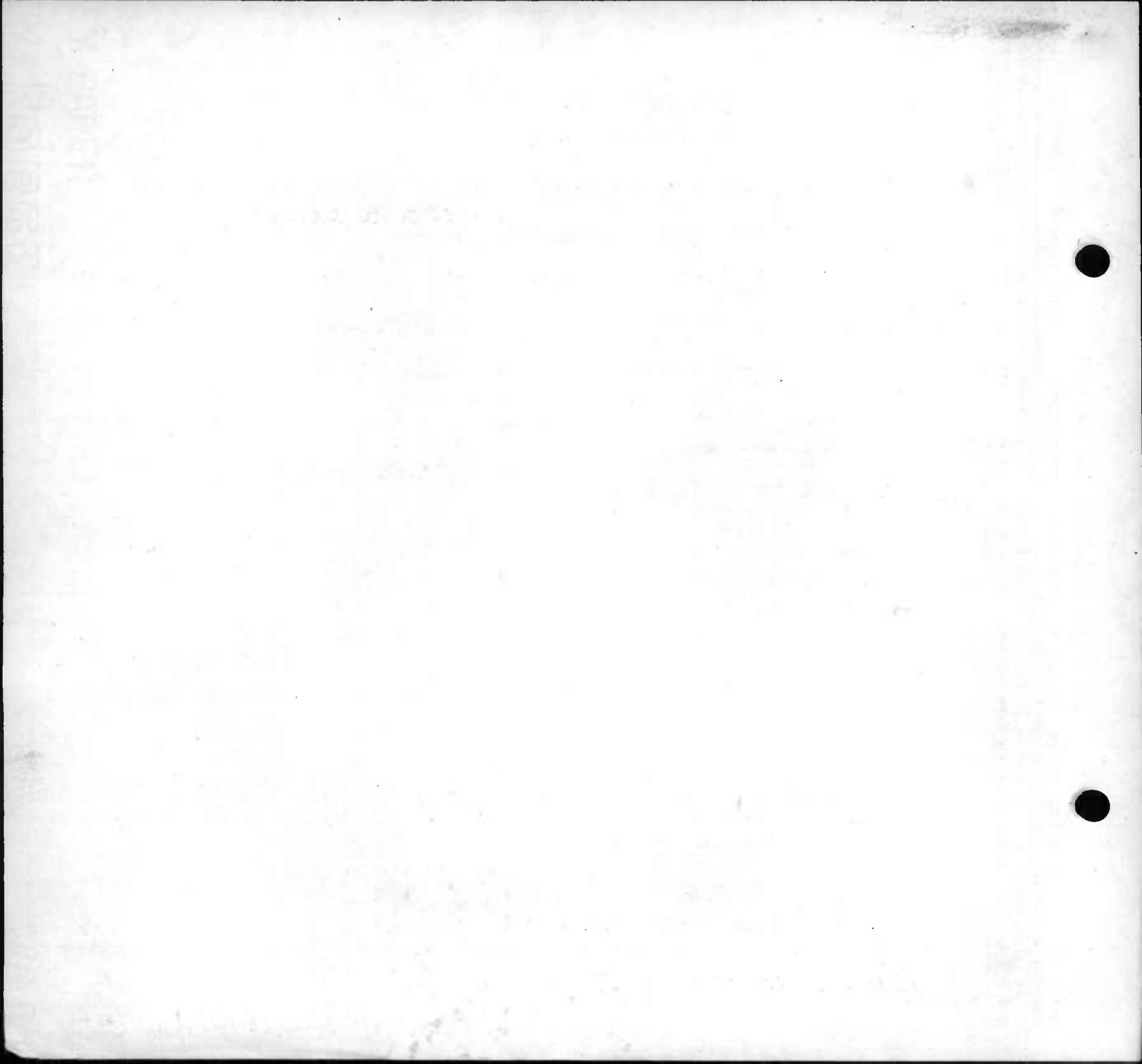
25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Charles R. Rice, 66 W. Barrett



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-1500

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

68-1500
REG. NO.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Harris, Mr. W. Hall, Jr.		2. DATE AND HOUR OF DEATH 2-5-68 11:20 am M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 12-02		
FULL NAME OF HOSPITAL OR INSTITUTION Keswick Home for Incurables 700 W. 40th Street Baltimore, Maryland 21211			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER #3209 N. Charles St.					
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 1, 1881	9. AGE (In years last birthday) 86
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10B. KIND OF BUSINESS OR INDUSTRY Law		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME W. Hall Harris			14. MOTHER'S MAIDEN NAME Alice Patterson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 216-42-6249		17. INFORMANT Mrs. Deponai, R.N.	
				ADDRESS Keswick	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Coronary thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) Atherosclerotic Heart Disease 2 yrs. (C) Cerebral arterial sclerosis			CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few hrs.		
19. DATE OF OPERATION 420.1 II			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from February 21 19 67 to February 5 19 68 , that (I) (we) last saw the deceased alive on February 4 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. Hunter Wilson, Jr. OEGREE				23B. DATE SIGNED 2-5-68	
23C. PHYSICIAN'S NAME (Type) E. Hunter Wilson, Jr., M.D. OEGREE				23D. ADDRESS 700 W. 40th Street, Balto, Md. 21211	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-7-68		24C. NAME OF CEMETERY or CREMATORY Greenmount	
24D. LOCATION Baltimore		24E. (City, town, or county) (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. FEB 7 1968		25B. NAME OF REGISTRAR E. Hunter Wilson, Jr.		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.	
				ADDRESS 4905 York Rd. Balto., Md.	

Robert Johnson

1878 - 1880

Amherst College